Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date . Month Chyanne Greenfield **Physician** 11:05 A M 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** N/A5. Social Security Number 8. Date of Birth (Month, Day, Year) 01/08/1951 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 X F Days Hours Min 60 105-42-0090 NY Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County Examiner must be notified at XX Yes 2 No Director 28a-f MD N/A BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō 23a 6705 WESTERN RUN DRIVE 21215 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any injury or other traumatic event. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian. Black, White, etc. 1 Never Married 2 XMarried 1 ☐ Yes If Yes, Give 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) **TEACHER EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MORRIS SHISGAL FAYE FEINSTEIN မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6705 WESTERN RUN DRIVE, BALTIMORE, MD MANUEL GREENFIELD/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HAR TAMIR CEMETERY 04/07/2011 JERUSALEM, ISRAEL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Malt 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): days disease or condition resulting in death) 00 Medical Examiner Bacteren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): 6 weeks Exami The law requires that the death certificate be executed Toxic epid g physician and as the burial-trans Due to (or as a consequence of): resulting in death) Last Box 68760. Physician/Medical for use as attending 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) signed by the at P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records. certificate has been signed lirector, page 2 should be 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 2 000 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ည 6 Other (Specify) After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 Yes 2 🗌 No 2 Accident s after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral E Hospital 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) atthew Sonerman 4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001 11595

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 1 Griffin Garnet 20 F Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Kris-Leigh Assisted Living Gambrills 8. Date of Birth

(Month, Day, Year)

April 6, 1919 Social Security Number 6 Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 289-05-8241 1 □ M 2 🖫 F 91 Director Ohio Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 193 12th Street 21122 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, . or Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: White "natural", Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Adkins Mary Distel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 193 12th Street Pasadena MD 21122 Dawn Cervenka /great-Nie¢e Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burja) i2 Cremation 3 Removal from State Holly Hill Cemetery 4/8/11 Baltimore MD 4 Donattion 5 Other (Specify) Balto. ML 2x 21221 . Signatur Funeral Savior License 22. Name and Address of Facility 300 Mace Ave. Connelly Funeral Home of Essex Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be as the IF FEMALE: use 23c, If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 mo detached for Month Yes 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed δ should be 2 No 3 Probably 4 Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? this certificate 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 🔲 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 5 Pending work 1 Yes 2 No Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifier 29b. Signature 29c. License number 006314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Monti

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Geisler, Sr. Day Month APril Year 50 P M Christian Physician/ 2011 Medical 4a, Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner N/A **Baltimore** 209 Pontiac Avenue 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth
Jan 29, 1941 Social Security Number . Age (In vrs. last birthday) If Under Months Year If Under 24 Hrs. **Funeral** Hours 1**₹** M 2 □ F 213-36-1626 70 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Baltimore N/A 1 X Yes 2 No Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21225 209 Pontiac Avenue Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc þ 1 Never Married 2 Married 1 😿 Yes 2 □ No If Yes, Give Year or Dates. Korea Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural" Completed 3 Widowed 4 X Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mantal Hygienstall Hygienstall Hygiens amportant. If item 27 is marked other than 'amy injury or other traumatic event, the Meanne. Elementary/Seconday (0-12) College (1-4 or 5+) Crate Company Laborer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Catherine Crispens Thomas Geisler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Sister) Helen M. Bateman 209 Pontiac Avenue, Baltimore, Maryland 21225 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Atlantic Crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Glen Burnie, Maryland 4/8/11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Folyniak Funeral Home, P.A. 21. Signature of Funeral Sema Licensee Kevin E Foker 237 E. Patapsco Ave., Balitmore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final canter Enysician/ Lung disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month Day 4 ☐ Pregnant at time of death g ☐ Unknown yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: ■ Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier M. D. MSKY MP MMM . D 29c. License number 29d, Date signed (Month, Day, Year, DOU57 465

Registrar
DHMH 17 Rev 7/2009

State

2835 Smin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

N.S. Rajapaks , MID

31. Date filed (Month, Day, Year)

Baltimore, MD ZROA

5-703

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 7/3 AM Clyde Hargis Jr. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FRANKLIN SQUARE HOSPITAL CENTER Rosedale BalTimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral (Month, Day Year) Nov . 23 1 XM 2 □ F Hours Min. 212-60-6439 59 **Director** MD Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 3710 Clarks Point Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 ☐ Widowed 4X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Oil Commercial Diver 4yrs Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harais ပ္ Clyde Hargis Sr. Alice F. Canterbury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany Seling /daughter 1408 Primrose Place Belcamp MD 21017 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 4/9/11 4 Donation 5 Other (Specify) Baltimore MD 21. Signe ture of Funeral Service Licensee, 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Shock PIIC disease or condition Medical resulting in death) Due to (or s a consequence of): Examiner n eumonia Sequentially list conditions, if any, leading to immediate cause E. ter Urnarrying Examine Due to (or as a consequence of): ending physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Arter Division of Vital Records, diseas 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cardiomyopath autopsy performed Yes 2 🗗 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053694 2011 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN SQUARE DR Balto md 212 37 4000 Daniel Shinners 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month APRII 2011 3:14 P M JOHN A. HELMER Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not Institution, give street and number) 4c. County of Death **Examiner** Baltimore Middle River 4025 Bay Drive If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex Age (In vrs. last birthday) **Funeral** Month, Day, Months Days Hours 1 X M 2 F . 1932 Mar√land Director 213-30-8488 78 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location Director 1 Yes 2 XXVo Baltimore County Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21220 4025 Bay Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Completed by Yes 2 No Yes, Give 7 C _{Specify}White 21215-0036 res, Give Year or Dates. 1953~55 Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Property Manager N/A 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) aryland ၉ Florence Virginia Negangast Bernard Theodore Helmer, Sr. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 4025 Bay Drive Baltimore, Maryland 19a. Informant's Name/Relationship (Type, Print) Lydia T. Helmer (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-11-2011 Baltimore, Md. Gardens of Faith 4 Donation 5 Other (Specify) Signature of Funeral Service Ligenses 22. Name and Address of Facility 7401 Belair Rd. Lassahn Funeral Home assol Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each in Set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sacruntially list nonditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year detached been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by $2 \square$ No $3 \square$ Probably $4 \square$ Unknown 1 Yes this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv page 2 performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) the funeral director. Be Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 5 Residence 6 Other (Specify) 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After injury work? Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Sulcide
4 Homicide Investigation 24 hours after deat Funeral Director: Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying furse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 To the F only one) 29b. Signature and title of certifie cause of death (Item 30. Name and address of person 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hygien [6] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Apr 5,20 pay Physician/ 9:55A M Michael Irvin Jones Medical 4b. City, Town, or Location of Death Towson4a. Facility Name (if not institution, give street and number) **Examiner** 4c. Copy of Permore Gilchrist Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 57 yrs Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) 1 X M 2 - F Hours 485-68-6860 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Direct N/A Baltimore Maryland 1 XYes 2 No 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a USA 4520 Saint Thomas Avenue 21206 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? 1X Yes 2 □ No If Yes, Give Black, White, etc. Black 0 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 In and Mental Hygiene.

7 is marked other than "r Special Needs Elementary/Seconday (0-12) College (1-4 or 5+) Children Resource Counselor Year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ada Sutton |Irvin Jones permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4520 Saint Thomas Avenue Baltimore, Maryland Ora P. Jones/ Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 4/129/11 cemetery, crematory or other place) 4/12
Holy Redeemer Cemetery 1 XBurial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funerl Home 4210 Belair Road Baltimore, MD 21206 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician, adehocarcinoma disease or condition weses Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, translating of the cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s autopsy performed' 1 🗌 Yes Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No |은 4 Nursing Home 5 Residence 6 Dether (Specify) Ho Spic O 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Quertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10070635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) swite 4105 Baltimore and Pact 701 Charle State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Medical Exami	ner	MICHAEL		OY JACKS						/	Month April 2, 2		Year		1417 hrs
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Funeral		5. Social Security N	lumber	6. Sex	7. Age (In y	rs, last birth		Jnder 1 Ye			B. Date of I	Birth (MM/		Birthpl	lace (State or
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Second	indary (0-12)	College (1-4 or 5+)	ST	ATE HI	GHWAY	OPER.	ATOR		нт	GHWAY	ADM	INISTRATIO
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Division of Vital Records, P.O. Box 68760, ital or Attending Physician: The law requires that the death certificate be extra after death. al Director: After this certificate has been signed by the attending physician led in by the funeral director, page 2 should be detached for use as the burial.	b P	Part II. Other signif	icant conditi	ons contributing to	death but n	ot resulting	in the underly	ring cause	given in Pa	rt I.			use contribut		cause of death?
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To the comple		one) 2 🗸		niner:On the basis of and manner s	of examinatio tated.	n and/or inv	estigation, in	my opinio	n, death oc	curred at the	e time, dat	e and pla	ce, and due	to the ca	ause(s)
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State of Maryland / Department of Health and Mental Hygiene	2

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Director		Usual Residence of Decedent	1 M 2 F	32	Yrs					2-16	-1 979)	Cou	intry) MD	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/M	1 Yes 2 No 9 ✔ Unkr		regnant at time of death 5 Other (Specify) nknown											
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	ľ	30. Name and address of person v Carol Allan, MD Assi	who completed cause istant Medical E	•	^{23a)} 111 Penn S	Street, Ba	altimore	e, MD 2	1201						
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Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2011 Physician/ James Patricia 1454 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore University of Maryland Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) oct. 8,1936 Days Hours 1 ☐ M 2**X**☐ F Months Ohio Director 286-30-9231 Usual Residence of Decedent 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Ellicott City Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 2754 Westminster Road 21043 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🔀 No Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry during most of working College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Homemaker Own Home Be 18, Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Lillian Adora Fields Rodman Douglas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2754 Westminster Road,Ellicott Citv,Maryland 21043 <u>Clarence L. James, III</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Westwood Cemetery 4-14-11 Oberlin, Ohio 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. Signature of Funeral Service License michael 6009 Harford Road, Baltimore, Maryland 21214 marrielle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intracranial Hemorrhage Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): s been signed by the attending physician and should be detached for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No 2 🗌 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗷 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature ar 29c. License number 2011 6880 WY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 MD 215 Greens St Ballimore AREH 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 11 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3 RUTH 2018 Medical 4a. Facility Name (if not institution, give street and number Examiner Town, or Location of Death 1055 140SF 10116 omery If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Florida 78-42-388 1 🗆 M 2 🔀 F Months Director ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MASHINGTON 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA ORNE items 2 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc ò ģ 1 A Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) omputer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Hawthorne dau 6HTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ò HESafeake Beltsville, MD any injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 420 H St. nE. 22. Name and Address of Facility WasH DC-20002 HEnry Funeral Home Henry m01178 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. HYPERTENSION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MEILITIS Sequentially list conditions, if any, Leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examin Hospital or Attending Physician: The law requires that the death certificate be executed 2) Week and that initiated events resulting in death) Last signed by the attending physician a d be detached for use as the burial-Physician/Medical disease Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Pregnant at time of death 2 X No 1 Yes 2 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 nknown neec Were autopsy findings available prior to completion of cause of 24a. Was an has h page 2 autopsy performed? this certificate Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 410 ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 Anatural 5 Pending within 24 hours after death

To the Funeral Director: / Accident 1 Tes 2 🗆 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D006868 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRN ROad, S.S. MD +OVES 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 John George Kasin 7:44A M April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HArford Upper Chesapeake Hospital Bel-air If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday **Funeral** Days (Month, Day, Dec . 29 216-52-6249 Months Hours Min. Country 1 X M 2 🗆 63 ,1947 Director MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at Director Jarrettsville Harford 1 Yes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21084 USA 3982 Norrisville Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. ģ 1X Never Married 2 Married Yes 2 XNo should be filed within 72 hours after If Yes, Give Year or Dates ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced "natural" Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important If item 27 is marked other than "natul any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Teacher 6yrs Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John G. Kasin Marion D. Salafie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Thomas Kasin /brother 9739 Manifold Road New Park PA 17352 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Bayview Crematory **β**urjal 2 XCremation 3 ☐ Removal from State 4/8/11 Baltimore MD Donation 5 Other (Specify) 21. Sign tute Furreral Service Lio Tsee 300 Ave. Balto. MD of Essex 21221 Ave. Mace Connelly Funeral Home Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ rour disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 🔲 Yes filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy 1 Yes 2 No 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA မ this 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗌 No death Investigation Could not be Accident To the Hospital or Attended within 24 hours after death To the Funeral Director: 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) Harford Road, Suite 105, Fallston, MD 21047 2. Registrar's Signa State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Month Year **Physician** Kuhn Joseph 225 APRIL 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 54. ALNES HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours 215-40-4992 66 April17,1944 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and it is an and Mental Hygiene. and: I flem 27 is marked other than "hatural", or items 23a or 28a-f show any or other traumatic event, I'm Medical Eran, iner in the multiple at any or other traumatic event, I'm Medical Eran, iner in the multiple at 10d. Inside City Limits 1∩a State 10h County 10c. City, Town or Location MD Baltimore Baltimore 1 ☐ Yes 🏖 ☐ No **Funeral Director** 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 200 First Avenue 21227 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: If Yes, Give Year or Dates: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Envolope Co. Laborer 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin B. Kuhn Catherine Joyce ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) K. Noel Spindler /niece 7114 Greenbank Road Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 4/6/11 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fringral Service Licensee 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 en Approximate Interval Between Onset and Death 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each like. Immediate Cause (Final Due to (or as a consequence of): **Physician** 10 YGARS disease or condition resulting in death) ARTERV /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 2. No 1 ☐ Yes 2 K No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 MNatural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ٥ MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 900 AVE VITTSERL A 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8,17&19a Per FH G914 4/11/2011 III State of Maryland Department of Health and Mental Hygiers 1 | 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last)

Edward R. 2. Date of Death 3. Time of Death Physician/ Krause Month 25/2011 5:10pM Medical 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore **Examiner** Envoy Nursing Home Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8 PO/251 1926 Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min Months Days Hours 165-20-7953 1 🔀 M 2 🗆 F 84 Director Usual Residence of Decedent 28a-f shov 10b. County of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director MD Baltimore Pikesville 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 Sudbrook Lane by Funeral death with 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Armed Forces? Army Black, White, etc. 1 Never Married 2 Married should be filed within 72 hours after Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: If Yes. Give Completed 3 Vidowed 4 □ Divorced Year or Dates. Air Force 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Health Educator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Lottie Dolvia ၉ Frank Krause Krauser 19a. I**fter 13 d**Name/Relationship (*Type, Print*) **Dave** Bickel 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1319 Church Hill Drive, Baltimore MD Nephew 21208 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place)

Forest Hills Mem. Park 4/1/2011 Reading, PA 1 Burial 2 Cremation 3 XX emoval from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Dod a²². Name and Address of Facility
Charles L. Stevens Funeral Home,
1501 E. Fort Avenue, Baltimore MD

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Ag 21. Signature of Funeral Service Licensee Victor Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be, within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should he determed for the funeral director, page 2 should he determed for the funeral director. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Other (specify) Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Check only one) Signature ar 29c. License number 29d. Date signed (Month, Day, Year) 00071287 Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 St. Suite 4105, heen State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 3 per doc g914 4-11-11 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GRACE MARIE KEEN 2011 APRI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GILCHRIST HOSPICE TOWSON Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** (Month, Day,) Aug. 18 Hours Min. 1 M 2 X F _{Country)} Mass 89 Director 023-16-8749 Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore County Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 USA 205 E, Joppa Rd. Apt. 704 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: 3X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bata Shoe 2 yrs. 12 yrs. Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Grace Woodhead John Reth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49 Glen Alpine Rd. Phoenix, Maryland Dawn A. Spring (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4-6-2011 Baltimore. Crematory Metro 21 Signature of Funeral Service Licenses 22. Name and Address of Facility
Lassann Funeral Home 0 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Obstructive pulmonary Ph_sician/ berna disease or condition Medical resulting in death) dister le to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant at time of death 9 Unknown To the Hospital or Attending Physician: The law requires that the deswithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) NOS 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Watural injury 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 5 2011 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST POUSON MO 6701 N Charles CHANNES AN) Registrar's Signat State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 7:20 A.M Evelyn Elizabeth Miles April 8, 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Long View Nursing Home Manchester Carroll If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2**XCX** 91 3, 216-20-0551 1919 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 4705 Alesia-Lineboro Road 21102 of America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married I □ Yes ②【XNo f Yes, Give Year or Dates: 1 ☐ Yes XX No Specify. Specify: ₩Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Dawes Williams Hildagarde Gruhn 19a. Informant's Name/Relationship (Type. Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Norma L. Schenning 4705 Alesia-Lineboro Rd., Manchester, MD 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 11, XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) New Lutheran Cemetery 2011 Manchester, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 23a. Pa . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causes each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequente f) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are the cause of t resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth in the past 12 months? 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2**Z**W0 3 Probably 4 Unknown 24a. Was an autopsy performed? 1□ Yes 2⊡ No 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 22 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar signed by the a d be detached f page 2 s

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical Completed by To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifica
completely filled in by the funeral director, p Be Certification: To

State

Medical

2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nd address of person who completed cause of death (Item 23a) (Type, Print) mp 31. Date filed (Month, Day, 32. Registrar's Signature APR 1 1 2011

1 ☐ Yes 2 ☐ No

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 201°1 JANE M. MURK 5:30A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore **Examiner** 4b. City, Town, or Location of Death 8905 Yvonne Avenue Baltimore County 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Hours Min. Director 213-03-3917 93 24 1918 Italy Mar Usual Residence of Decedent 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Baltimore County 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 8905 Yvonne Avenue USA "natural", or items Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 XXIo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 _{Specify}White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Public Food 8 yrs. Store Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ဂ Emilio D'Alessandro Incoronata D'Alessandro Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AUF Raymond Murk (Son) 4625 Madonna Rd. White Hall, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If It 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 4-8-2011 Baltimore, Md. Signature of Funeral Service Licenses 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Balt tho Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ ta eno carcindina disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** mouths Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 ☐ Yes ∠ ⊭ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director. After this certificate it completed filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to prédical Be 26. Place of Death (Check only one) 2 No ပ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 4 \(\sum_{\text{Nursing Home}} \) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 Accident
3 Suicide 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and A 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) enter Seffrer 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 7/2009

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Appril 6 2011 Year Physician/ Franklin J. Norvell 17:05 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Middle River Baltimore 1609 Dornton Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 XM 2 F Months Days Hours 220-18-9163 March17, 1925 86 MD Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Middle River 1 Tes 2 K No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1609 Dornton Avenue 21220 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status rmed Forces?

Yes 2 \sum No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: White 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4yrs & Fender Teacher Baltimore County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John J. Norvell Mary Foltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050 Marylou Rogers /daughter 2411 Edwards Manor Drive Forest Hill MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 4/9/11 Baltimore MD 4 Doffation 5 Other (Specify) ryce Licens 21. Sign of Funeral S 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -₹nysician/ ROMAR Medical resulting in death) Due to (or as a consequence of); Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated exerts. Due to for as a consecuence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available Cancer cate has t page 2 s autopsy performed? Yes 2 No prior to completion of cause of death? certificate tension eR 1 ☐ Yes 2 XNo 25. Was case re rr d to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ္ 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Suicide after death

Director: A

d in by the f Investigation 6 Could not be n 24 hours after de e Funeral Directo eleted filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) enan

Registrar
DHMH 17 Rev 7/2009

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State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Patel Ila 4:00 AM MPRIL 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Baltimore Northwest Hospital (Seasons Hospice) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours Feb. 23 ^{Year}1950 India 347-80-5125 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Reisterstown MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b USA 805 Carriage House Ct. 21136 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Indian 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Quality ControlManager Lab Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kantibhai Pate1 Shantaben 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 Carriage House Ct., Reisterstown, MD 21136 Arvind Patel (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltunore Cremeusty Loudon Park 1 Burial 2 Cremation 3 Removal from State 4/9/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition h sician/ Multiple Myeloma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to minimum added cause. Enter Underlying but to (or as a corresquence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Day Year 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 ☑ No certificate 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Other: ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MS Rajapalise MID D0057465 417/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Bultimore, MO. ZIZO9. apakse, 2835 · S Raj 5-203 Smili 32. Registra 's Sign

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, 11-01774 State of Maryland / Department of Health and Mental Hygiene Gordon Ridgeway, Jr. Certificate of Death 1- For State 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3 Time of Death Physician/ Month Day March 5, 2011 0515 hrs Gordon David Ridgeway, Jr. Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Northwest Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5 Social Security Number 237-55-8845 6 Sex **Funeral** Foreign Country) CA Months Days Hours 2/28/83 Director 1XXM 2 F 28 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State MD 10b. County Baltimore Reisterstown 1 Yes 2 X No 28a-f show mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland partnern of Health and Mental Hygiene.
portant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic eveot, the Medical Examiner must be notified at occa. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 Carlton Crest Ct. 21136 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 X Married 2 X No Yes White Specify: 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementery/Secondary (0-12) Food 12 Baltimore, MD 21215-0036 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gordon D. Ridgeway, Sr. Sharon Ackiss Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lorisa L. Ridgeway/Wife 6 Carlton Crest Ct, Reisterstown MD 21136 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Ardent Crematory 3/9/2011 Hanover MD 4 Donation 5 Other Specify: Signatur of F al Service Licensee V1C or Doda

22. Name and Address of Facility
Charles L. Stevens Funeral Home,
11501 East Fort Avenue Baltimore

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

Appl Physician Between Onset and failure. List only one cause on each line /Medical Heroin and Cocaine Intoxication Immediate Cause (Final disease ≛xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause se or injury that initiated Physician/Medical

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physiciae: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transit

<u>6</u>

Completed

Be

Certification:

Medical

State Registrar

29b. Signature and title of certifie

Pamela E. Southall, MD

31. Date filed (Month, Day, Year)

events resulting in death) Last	Due to (or as a consequence of):	
d.		
X UNPENDED	AMENDED 23a,27,28a-f per me g914 4-13-	ll vt
IF FEMALE:	23c. If yes, outcome of pregnancy	23d. Date of delivery
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnant 4 Pregnant at time of death 5 Other (Specify)	cy Month Dey Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 2 No
25. Was case referred to medical	26.Place of Death (Check or	ily one)
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing	Home 5 Residence 6 Other:
27. Manner of Death	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2	8d. Describe how injury occurred
1 Natural 5 Pending 2 Accident Investigat	fd 3-5-11 fd 4:07 am 1 Yes 2kk No	unknown
3 Suicide 6 X Could not	28e Place of Injury - At home, farm, street, factory, office building, etc.	8f. Location (Street and Number or Rural Route Number, City
4 Homicide determine		6 Carlton Crest Towson, Md.
29a. Certifier 1 Certifying Physic	cian: To the best of my knowledge, death occurred at the time, date and place, and d	ue to the cause(s) and manner as stated.
one) 2 Medical Examine	or:On the basis of examination and/or investigation, in my opinion, death occurred at	the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of son who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

March 5, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 200 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Elkridge 6636 Washington Blvd Lot 77 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthpiac Country) MD 5. Social Security Number 216-58-9833 **Funeral** 1 X M 2 □ F Days Hours 0870971951 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Elkridge 72 hours after death with the Maryland 10a. State MD Director Howard 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA items 23a Funeral 21075 6636 Washington Blvd Lot 77 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or item I Examiner n 14. Race - American Indian Black, White, etc. White 1 Never Married 2 M Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 hr
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Sheet Metal Industrial Finisher . Mother's Name (First, Middle, Maiden Surname) Mary Jane Martin 17. Father's Name (First, Middle, Last) George Laurence Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6636 Washington Blvd Lot 77 Elkridge MD 19a. Informant's Name/Relationship (Type, Print) Anna Marie Roberts Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Atlantic Crem 1 Burial 2X Cremation 3 Removal from State 04/06/2011 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Funeral Service Licenses ThomasAllenPA 7090 Ridge RD Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Heputoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Month signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death

1 Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 4-4-17 30573 ND ddress of person who completed cause of death (Item 23a) (Type, Print) harter Dr Columbia MD 21044 On 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician/ 8:30 P M 2011 <u>Francis G. Russo</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 3<u>99 1st Avenue</u> Halethorpe Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Delaware Min (Month, Day, Year) 3/22/25 Hours 1 **M** M 2 □ F Director 219-18-3105 86 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 🗌 Yes 2 🔀 No MD Baltimore **Halethorpe** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21227 399 1st Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: 3 > Widowed 4 Divorced Year or Dates. WW II White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Social Security 12 Claims Examiner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Francis G. Russo Sr. Frances Brogan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brunswick Rd. Halethorpe, Maryland Nina M. Tischler / Daughter 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Loudon Park Funeral Home 3620 Wilkens Baltimore. Marvland Ave mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or of shock, or leart failure. List on Approximate Interval Between one cause on each line. Onset and D Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the lirector, page 2 s autopsy performed?
1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be 2 No မ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATON AVE 900

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #768 Per FH G914 4/11/2011 JH Department of Healthyand Mental Hygiene Per Dyk 1916 6/19/1919 Mental Hygiene Certificate of Death For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3/26 Physician/ ັ້2011 6:19p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dove Carroll House Westminster 7/04/1923 If Under 1 Year If Under 24 Hrs. Social Security Number 159-22-6526 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** 1 □ M 2XCXF Months Days Hours Min 94 81 Yrs. 87 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits **Funeral Director** MD Carroll Taneytown 1X Yes 2 ☐ No 10e. Street and Number 310 Clubside Drive 10f. Zip Code 10g. Citizen of What Country? 21787 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11, Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Department Manager Retail Be 17. Father's Name (First, Middle, Last)
Clarence C 18. Mother's Name (First, Middle, Maiden Surname) Čole John ပ Ida 19a. Informant's Name/Relationship (Type, Print)
Raymond Stickles / 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
310 Clubside Drive, Taneytown MD 21787 Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of PA Date 1 Burial 2 Cremation 3XXRemoval from State Green County Mem Park 3/30/2011 Morgan Township 4 ☐ Donation 5 ☐ Other (Specify) Doda 22 Name and Address of Facility Evens Funeral Home, 1501 East Fort Avenue, Baltimore 21. Signature of Funeral Service Licensee Victor Ρ. Inc MD 2123), C 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AGE DEHENTA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🔲 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an cate has to page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tminster AVENL toner 25 31. Date filed (Month, Day, Year) 2. Registrar's Sigr State 2011 APR 11 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elsie Spell Physician/ 12:45 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Hartford Garden Rehab Cente If Under 1 Year if Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) 6. Sex Funeral Social Security Number 215-34-7996 Days 1 🗆 M 2 🖾 🗶 (Month, Day, Year) 4 77 Director NC Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10b. County 10c, City, Town or Location Examiner must be notified at Funeral Director N/A Baltimore XX Yes 2 No 10e. Street and Number 4700 Harford Road 10f. Zip Code 10g. Citizen of What Country? 21214 items 23a USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 5 Completed by 1 Never Married 2 Married 2 **X**No permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examit Yes Yes, Give Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-40r 5+) Private Home Domestic Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ollen Bullock Lawrence Annie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jacqueline Black/Daughter 6 Boykins Lane, Hampton VA 23663 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crowells Baptist Church Cem 20c. Location - City or Town, State 1 Durial 2 Cremation 3 N Removal from State Halifax, NC 4 Donation 5 Other (Specify) 21. Signature of Feneral Service Licensee Victor Doda ²Chame and Address of Facility tevens Funeral Home, 1501 E. Fort Avenue, Baltimore MD Inc. 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Due to (or as a const uence of): Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in the cause (Disease or linjury) Examiner Due to (or as a consequence of): **To the Hospital or Attending Physician:** The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): iding physician a Physician/Medical Di seene Jont Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Sely zolomoremo 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 400 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to ompleted filled in by the funera 1 Natural 5 Pending 2 🗌 No 1 Tes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F21 N. EVATAW ST Smite 368BALTIMEREMD2/201 HA-SHMI MD SITOAILS 31. Date filed (Month, Day, Year) State Registrar

M DHMH 17 Rev 7/2009

		I	AMEND PI LINE B 25 1- State Amend line 2 Registrar	Type of Pri	nt in Black	Jndeli 1930eli)	. Ensure	All Copie	s Are L	egible.	
			1- For Amend line 2	23a, 27, 28	aryland / De Ba-f, per	ertifica	1938 16 <i>of L</i>	1eaith and 14-9-201 Death	.3, GDY	Reg. No.	0	11526
	Physicia		1. Decedent's Name (First, Middle, La	ast)	-				2. Date of Do Month	eath Day	Year	3. Time of Death
2	Medic Examir	cal	William T. Swift 4a. Facility Name (# not institution, give			4b. Cit	y, Town, or	Location of Dea	Herit	4c. Co	unty of Death	23:56 M
	./		University of Maryla		Center	\rightarrow	er 1 Year	If Under 24 Hrs	Do Dote of Di		O Dista	(Clate of Family)
	Funeral Director		217-54-3515	1 X XM 2 □ F	e (In yrs. last birthda 60 Yrs	Month		Hours Min			Count	ace (State or Foreign MD
	and show	ē	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or					<u> </u>	10	d. Inside City Limits
	e Maryl r 28a-f notifie	Sirect	MD 10e, Street and Number	N/A				ore Ci	ty ———	40011	(11/1 - 1-0	1XX∕es 2 □ No
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9	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ॲNever Married 2 ☐ Married	14. Race - American Indian, Black, White, etc.								
-003	ours af	eted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	160 Do	1 ∐ Yes cedent's Us		Specify:				ite
21215-0036	nin 72 h ne. han "na e Medie	dmo	(Specify only highest of	rade completed) College (1-4 or 5	(Gi	ive kind of w . DO NOT u	ork done c se retired)	luring most of wo	orking	1	of Business Ind Shippi	·
	iled with Il Hygier other t	Be	12 17. Father's Name (First, Middle, Last, Joseph T.	0		ongs	nore	18. Mother's Na	ame (First, Middle	, Maiden Suri	name)	.19
Maryland	uld be f I Menta narked natic ev	욘							rgaret ———			
	nd 2 sho ealth and n 27 is n er traur		19a. Informant's Name/Relationship Joseph Swif	t /Brothe	er 29 ^M	ailing Addre Dean	ss (Street a Ave	nue, Jo	ural Route Numb Ohnstor	er, City or Toy 1 RI (7291, 200 	ode)
Baltimore,	age 1 ar ent of He nt: If iter y or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		20b. Place of Discernation Ardent	sposition (Natrematory or Cre	ame of other place mato	e) rv 4/	Date 5/2011	1	ion - City or To	_{wn, State} aryland
3altir	permit. P Departme Importar any injur		21. Signature of Funeral Service Licer	**					vens Fu	1		
	00 = e o	H	23a. Part 1. Enter the disease, or cor	nplications that caused	the death. Do not e						nore M	Approximate
E	enysician/		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line	4.5							Interval Between Onset and Death
	/ Medical Examiner		resulting in death)		a consequence of): MUR FRACT	FURE W	TTH (COMPLICA	TIONS		1)	-
	d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	D	з оспрация ю сту:				0 1	Infay MEDI	AL EXAMINE	
	cate be executed physician and s the burial-transit	I— I	that initiated events resulting in death) Last	C. Due to (or as a	a consequence of):		•	CEF	TIFICATIONS	MED		
09/	physicia the bur	edica		d					· · · · · · · · · · · · · · · · · · ·			
Box 68760	eath certifica attending p	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 ☐ Ectopia	pregnanc	v		230	. Date of delive	ry
	ne death / the att ched fo	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown		5 Other (<u></u>			Month	Day Year
, P.O.	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director. After this certificate has been signed by the attending physici sted filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.		Part II. Other significant conditions	contributing to death b	ut not resulting in th	e underlying	g cause giv	ren in Part I.				e cause of death?
Division of Vital Records,	v require been si should	Completed by							1 L 24a. Was			ably 4 Donknown sy findings available
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/ital	Physician: The this certificate had director, page	Be	25. Was case referred to medical examiner? 1 X Yes 2 100	Hospital:			Othe	ace of Death (Che				
of \	ng Phy fter this ineral d	ite: To	27. Manner of Death	28a. Date of injui		of	28c. Injury work	4 ∐ Nursing ⁄at	Home 5 Res 28d. Describe			·- ·-
sion	Attendi death. ctor: A y the fu	Certificate:	2 2 	be 280 Place of Inju	IT UNK	M street facto	1 🗆	Yes 2 No	SUBJECT 28f Location		-	Route Number
Divi	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral		4 ☐ Homicide determined	building, etc	. (Specify)	011001, 14010	.,,,		City or To	wn, State) 8 ROSEDAI	100 ROS	SVILLE
	le Hosp n 24 hou le Fune bleted fil	Medical	(Check 2 Medical Exam	ysician: To the best of niner: On the basis of ex rse Practioner: To the	kamination and/or inv	restigation, in	n my opinio	n, death occurred	at the time, date	and place, and	d due to the cau	se(s) and manner stated.
	To th Within	~	29b. Signature and title of certifier		,		c. License	number			gned (Month, E	
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	e, Print)	1104	14 166 7		Horil	oi, de)((
			Bryan Moore	807 Sou	th Harov		freet	Baltin	one, mi	219	30	
	Stat Registra		31. Date filed (Month, Day, Year) APR 11 2011	32. Registra	r's Signature							

11-02635 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Noah Emmanuel Szabo State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Medical Examiner Noah Emmanuel Szabo 1617 hrs April 6, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days Director Months Hours 2000 country) Maryland 1XX M 2 F Feb. 3, 214-57-7679 ll Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 XXNo Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoo or other traumatic event, the Medical Examiner must be notified at once. Maryland Carroll Manchester Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 3201 Keating Court 21102 America Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' White, etc. 1 XX Never Married 2 Married Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 XX No specify: Specify: White ۵ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Elementary School Student Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Markus Sandor Szabo Laura Ferretti ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Markus S. Szabo (Father) 3201 Keating Court, Manchester, Maryland 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date April 9, 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State crematory or other place) Important: 1 Donation (5 Other Specify: Lake View Mem'l Park 2011 Sykesville, Maryland 1. Signature of Fundral Service Lis 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. <u>3296 Charmil Drive, Manchester, Maryland</u> 🎮 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Approximate Interval failure. List only one cause on each line Between Onset and Medical Death a Toxic Megacolon Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED AMENDED attending physician or use as the burial 23a,pt.II,27,g915 5-16-11 sm law requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 9 1 Yes 2 ✓ No 3 Probably 4 Unknown Autism Completed page 2 should has been 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of performed? death? To the Hospital or Attending Physician: The l within 24 hours after death.

To the Funeral Director: After this certificate l completely filled in by the funeral director, page Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Division 5 Pending 1 Yes 2 No 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 7, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Laron Locke MD. 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State

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arket

32. Registrar' Signatu

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** M 0 05 8 2011 LAWSON A. SCHRATKE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Counfy of Death Examiner Rosedale Date of Birth (Month, Day, Year) BalTimore FRANKLIN SQUAVE HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1**√**M 2□ F Director 214-20-9868 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County nd other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 X No Maryland Baltimore Baltimore County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with Funeral 21236 USA 4905 Linda Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1**X**X es 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 21215-0036 Korean 1 ☐ Yes 2 ☐ No Specify White <u>S</u> Specify: 3 Widowed 4 Divorced Conflict Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. other than "I Elementary/Secondary (0-12) College (1-4or 5+) <u>Office</u> 10 yrs. N/A MTA18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fill iment of Health and Mental Hiant: If item 27 is marked other. permit. Pages 1 and 2 should be Department of Heath and Menta Important: If Item 27 is marked any injury or other traumatic ewoors. Alexandra Schratke ဨ Elizabeth Bartenfelter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine R. Schratke (Wife) 4905 Linda Avenue Baltimore, Md. 21236 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 4-9-2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. ^{22. Name and Address of Facility} Lassahn Funeral Home 7401 Belair Rd. Baltimore, 21. Signature of Funeral Service Licenses Jassahn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** arresT Due to (or as a consequence of): UNKNOWN /Medical **Examiner** heart Failure Congestive Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Tue to for as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Kidner disease UNKNOWI chronic and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an has 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide e Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Yuling Zhang. D70605 April, 05, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

3

DHMH 17 Rev 1/2001

DR Yuling

31. Date filed (Month, Day, Year)

Zhang

FRANKLIN

9000

32. pegistrar's Signature

Square DR Balto md

Ronald Bruce Stilley

11-02362 UNK UNK

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

K OI	ui.		- For State	e or maryana r	Certificate	of Death			Reg. No.	(0.0)				
	Physicia I Exami	an/	Registrar 1. Decedent's Name (First, Middle, I Ronald Bruce	.ast) Stilley				2. Date of Dea Month March 27	Day Year	3. Time of Death 1025 hrs				
	Exami	IIIGI	4a. Facility Name (if not institution,			4b. City, Town, o	or Location of E	Death	4c. County of Bal	Death timore				
			3500 Poole Street	Co	In yrs. last birthday		ear If Under 2	24Hrs. 8. Date of B	irth(MM/DD/YYYY)	9. Birthplace (State or				
	Funeral Director		IInlenerm	Sex 7. Age (5.0	Yrs. Months Da		Min. 09/03	3/1960	Foreign Country) MD				
	ķ		Usual Residence of Decedent 10a. State 10b. County		10d. Inside City Limits									
	l low any E.			Arundel	Brookl	yn				1 Yes 2 No				
	uryland Sa-f sh at onc	ctor	10e. Street and Number 10f. Zip Code 10g. Citizen of What 4607 Kramme Ave 21225 USA											
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	or deat	F	3 Widowed 4 Divor	White										
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ဖွ	72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+	-)	Painter		,	Home	e Improvement				
003	within giene.	I I	1 0 17. Father's Name (First, Middle, I	ast)		_	18.Mother's	Name (First, Middle	, Maiden Surname)					
21215-0036	e filed tal Hyg ked utl nt, the	BeC	Calvin Limzy				Fra	nces Ara	abel Par	ker				
213	id Men is mar	P	19a. Informant's Name/Relationsh Mistey D. St	ip (Type, Print)					umber, City or Towr					
N N	nd 2 shalth an		20a. Method of Disposition	Tiley Daug	20b. Place of Di	sposition (Name of		Date	20c. Location -	City or Town, State				
Baltimore,	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23s or 28s-f show Important: If item 23s or 28s-f show Injury or other traumatic event, the Medical Examiner must be notified at ouce.		1 Burial 2 Cremation			or other place) tic Cren	n	04/1/201	Glen	Burnie MD				
ltim	artmen		4 Donation 5 Other Sp. 21. Signature of Funeral Service I			22. Name and Addr	ess of Facility	Simplic	ity Crem	a & Fun Serv				
ä	Dep Inju		23a. Part I. Enter the disease, or	All		ThomasA]	lenPA	7090 R	idge Rd arrest, shock, or hea	Hanover MD art Approximate Interval				
	hysician Medical		23a. Part I. Enter the disease, or of failure. List only one cause of	on each line.						Between Onset and Death				
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Box 687	h certii tending	Physician/	past 12 months?	4 Pregnant at	time of death 5	Other (Specify)								
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5	v require s been si	ompleted			_·				utopsy	Were autopsy findings available prior to completion of cause of				
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	To the	completely	one) 2 ✓ Medical Example 29b. Signature and title of certific	and manner stated.			cense number			ned (Month, Day, Year)				
		1	(/ water	(16)		С	C.M.E.		March 28,	, 2011				
	\emptyset		30. Name and address of person	who completed cause of o	death (Item 23a)	Dann Circai D	altimora M	ID 21201						
	W			Assistant Medical Ex	aminer 111 ar's Signature	Penn Street, B	aitimore, M							
	Pos	Sta		32. Registra	ar a digitature	'9								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Verna Alberta Logan Sweeney Physician/ 04707/2011 Mq00:8 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cecil Elkton Union Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) MD Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Days Months Hours Min. 0 9^{Mpnfh}5^D9^y1^Y9^y1 5 217-16-9207 95 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland Director Perryville MD Cecil 1 Yes 2 No 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21903 Funeral 345 Broad Street Apt 4 USA 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item ZT is marked other than "natural", or any injury or other traumatic event, the Medical Examir any injury or other traumatic event. Completed by 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Interior Designer Interior Design Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Elizabeth Hague Howard Passmore Logan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Howard Street North East MD 21901 19a. Informant's Name/Relationship (Type, Print) Dana W. Poore Niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of At lemeter lemetocor other place) 04/09/11 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Funeral Thomas Allen PA 7090 Ridge Rd Hanover MD 21. Signature of Tyneral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ NEUMONIA WITH disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?

1 Yes 2 No Month Day Year cate has been signed by the page 2 should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No this certificate Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😿 No Hospital ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Funeral Director: After completed filled in by the funer injury work? 1 ☐ Yes 2 ☐ No 5 Pending 1 Natural Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 08 (1) Br- None D 000 65733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NARAYANA RAD V. PULA 126 STREET ELKPA E. MOH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:15p 4, LUELLA R. STEVENSON APRIL 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FUTURECARE ROLAND PARK BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 X F Director 92 MARYLAND <u> 218-01-6414</u> 5-4-1918 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 □ No MD. N/A BALTIMORE by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3807 WABASH AVE 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: BLACK 3√ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12-SUPERVISOR GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JAMES A. ROGERS ELIZABETH BRANSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA BROWN (NEICE) 3807 WABASH AVE. BALTIMORE, MARYLAND 21215 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 🖺 Burial Cremation 3 ☐Removal from State GARRSION FOREST VETERANS 4-12-2011 OWINGS MILLS, MD. 4 Donati n 5 🗆 Other (Specify) Fund Service Licensee ONATHAN D. HIBNER 2. Name and Address of FacilityPHILLIPS FUNERAL HOME, P.A. 21. Signature 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Inter the dis shock or heart failu Immediate ouse (Final disease or condition resulting in death) ater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 Unknowr Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient Nann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD ham woods Parlittle MD21231 8813 31. Date filed (Month, Day, APR 11 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH G914 4/18/2011 JH
State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Patricia Ann Senft Physician/ March 31 9:15 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6801 White Water Way, Unit 203 Glen Burnie Anne Arundel Social Security **1550** 218-36-7558 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Aug 4, 1940 **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 1 M 2 X I Hours 70 Director Maryland Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8234 Great Bend Road 21061 USA ral", or items 2 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Ş Black, White, etc. 1 Never Married 2 Married 1 Yes : 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", Completed 3 Widowed 4 X Divorced Specify. White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Reliable Liquors Account Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herbert Watts Ann L. Leidig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. LeCompte (Sister) 103 Water Fountain Way, Unit 104, Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Dulaney Valley Mem. Gdns. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/5/2011 Cockeysville, Maryland Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility Mcully-Folyniak Funeral Home, P.A. 237 E. Patapsco Avenue, Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PANCREATIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death signed by the a d be detached f 1 Yes 2 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Tes FRIEND'S မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 💆 Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of HOME Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending death. Accident Investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl

To the Funeral Director:
completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 201 30. Name and address of person w o completed ca e of death (Item 23a) (Type, Prin State Registrar

11-02514

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Bjorn Servius Tho		aS 1- For State Registrar	State o	of Maryla		partment ertificate			and N	Mental I	Hygiene		201	Resident - titl	1153
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To the How within 24 h To the Fur completely	or	e) 2 ✓ Medical E b₀Signature and title of cert	kaminer:On and	the basis of e I manner state	xamination a	and/or investig	ation,	in my opinio	on, death	occurred a	at the time, date	and pl	ace, and due t	o the (cause(s)
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4	-	Medic Examin		4a. Facility Name (if not ins		reet and numb	er)				Location o	of Death			c. County		
		Funeral		2434 W. Be Levindale 5. Social Security Number	1693 6. Sex	7	. Age (In yrs. Ia	ast birthday)	If Under		If Under a	24 Hrs. 8	B. Date of Bi	rth		9. Birthp	blace (State or Foreign
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	Jaryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	rector	10a. State 10b.	County			y,Town or Loc altimo								1	0d. Inside City Limits 1X Yes 2 □ No
	with the A	23a or 2 ust be no	Funeral Director	10e. Street and Number 4701 ½ Fa	lls Rá	i .			10f. Zip	Code 209				10g. C	itizen of V USA	Vhat Cour	ntry?
	6 er death	or items miner m	by Fun	11. Marital Status 1 Never Married 2		2. Was Decede Armed Forc 1X Yes 2	es?	If	Yes, spec	cify Cubar	n, Mexican	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)	-		e - Americ k, White,	an Indian, etc.
	-003	atural", cal Exa	eted !	3 Widowed 4 D	ivorced Decedent's Edu		Oct.1	951-00 16a. Deced	ct.1		Specify:			4.Ch	Specify:	ртα	
	1215- thin 72 h	ne. than "na ne Medic	Completed	(Specify on Elementary/Seconday	ly highest grade	Completed) College (1-4	or 5+)	(Give k life. DC	ind of wor NOT use	rk done d e retired)	uring most	of working	7			usiness Inc	
	nd 2.	al Hygie d other went, th	æ	10th 17. Father's Name (First, N	liddle, Last)			Ste	<u>eelw</u>	orke	18. Mothe	,	First, Middle	, Maider	Surname		Steel Co.
	rylan	d Menta marked matic e	Ţ.	John Tur			•	10h Mailin	A duo.o.o.	/Street =			Bell Route Numb				Padal
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	Baltimore, Maryland 21215-0036	nent of H ant: If ite ary or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cre 4 ☐ Donation 5 ☐ 6	mation 3 🗆 R	emoval from S	tała C	Place of Dispos emetery, crem rriso l	atory or o	ther place	Ar Cer	or. ${ m P}_{ m n}$	₽,201	1 ^{20c. l} Ow	ings	City or To	own, State 1s , MD
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y	Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be expected to the Hospital or Attending Physician:	attending physician and for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months	ZIIL		rth 2 🗌 Feta	al death 3			y					te of deliv	,
). Bo the deat	by the at ached fo	hysic	1 Yes 2 No		4 ☐ Pregna 9 ☐ Unkno	int at time of o	death 5 L	Other (sp	pecify)					Mo	nın	Day Year
	S, P.C	been signed by the should be detached	by	Part II. Other significant of	conditions conf	tributing to dea	th but not res	ulting in the u	nderlying (cause giv	en in Part I						ne cause of death?
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	al Re	certificate has rector, page 2	Φ	25. Was case referred to m	nedical					26. Pla	ice of Deat	h (Check o	1 Yes	2,57		1 Yes	2 🗆 No
	f Vita	this certific al director,	To B	examiner? 1 Yes 2 No 27. Manner of Death	Но	ospital: 1 ☐ In 28a. Date of	-	ER/Outpatien 28b. Time of		_	4 Nu		e 5 🗆 Res)
	on o	eath. or: After he funer	Certificate:	1 Natural 5 ☐ 2 ☐ Accident	Pending Investigation	(Month,	Day, Year)	injury	M 2	8c. Injury work' 1 🔲	at ? Yes 2 🗆		ld. Describe	how inju	iry occurre	ed	
	Divisi al or Att	s after de Il Directo d in by t		3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined		f Injury - At ho , etc. (Specify	ome, farm, stre	et, factory	, office		28	3f. Location (City or To			er or Rura	Route Number,
	e Hospit	within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral director.	Medical	(Check 2 Me	rtifying Physic dical Examine rtifying Nurse	r: On the basis	of examination	and/or investi	gation, in	my opinio	n, death oc	curred at the	ne time, date	and plac	e, and due	e to the ca	use(s) and manner stated.
1.02	To the	within To the comp	2	29b. Signature and title of	certifier			, movioago, a	290	. License	number			29d. D	ate signe	d (Month,	Day, Year)
				30. Name and address of p	person who cor	H 4 S I C	of death (Item	23a) (Type, P	rint) L	EVIN	SALE	= 0	i GRIA	TRI	C C	TR	- 2011
7	,	Stat		BASAT NA 31. Date filed (Month, Day,	Year)	AJ AT	istrar's Signat) 2 l	+34	W.	SELV	160CA	LE A	E.L	SALT	MOR	E M) 21215
W		Registra		APR 1	1 2011	Cem	m p	. pa	Mes.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6^{Day} Physician/ 20°11 7:30 PM **TERRANOVA** MARY Μ. Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Arundel Anne 120 Dale Road Pasadena If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Country) 1 🗆 M 2 🔀 F 69 MD Director 219 38 5390 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2.X No Anne Arundel Pasadena MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 120 Dale Road 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ₩ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade >mpleted) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Bartender Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Goschen Andrew Catherine A. Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21122 120 Dale Rd Pasadena, MDAntoinette Keane - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 4/7/2011 4 Donation 5 Other (Specify) w Crematory: 4///2012.

22. Name and Address of Facility GJ Gonce Funeral Home,

Pacadena. MD 211 Baltimore, MD 21. Signature of Funeral Service Licenses Riviera Drive 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Caucer Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce use contribute to the cause of death? Completed by 1 ■Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? this certificate h 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Mann of Death Director: After that in by the funeral 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral I

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier man 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21237 910 FRANKL 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 April Physician/ АМ 1:05 4 Carolyn Varinski Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 9107 Lincolnshire Court Parkville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral Days Hours 1 🗆 M 2 💢 F Months June 16.1943 Maryland 219-42-7025 Director 67 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Parkville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 9107 Lincolnshire Court 21234 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Midowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Gas & Electric Co. Credit Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sadie Louise Sonn Charles Nelson Culver, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, **21224** 8009 Eastdale Road Baltimore, Maryland Friend Geraldine E. Fassell 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dulaney Valley Memorial Gardens 1 Burial 2 Cremation 3 Removal from State injury or 4-9-2011 Timonium Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Signati 21204 1050 York Road Towson, Maryland lus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastat disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Securation but expellions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last yper tension the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl autopsy performed 1 Yes 2 No Yes 2 25. Was case referred to medica B B 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ြို 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 🗆 No Accident
Suicide Investigation Could not be 28e, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Below Rd Baltimore MD 7602 MI Doule limoth State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 16a, 19a per fh g914 4-15-11 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month A P Venley 3:15 A M KOMA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Seasons Hospice Randallstown Social Security Numbe 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Months Days 216-18-3164 Yrs Director 86 Usual Residence of Decedent show or 28a-f shoven should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 138 N. Culver Street USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 Divorced Specify: African-American other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working

Do Current NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12th Documet Photography Social Security Admin. Be Father's Name (First, Middle, Last) Richard Veniey 18, Mother's Name (First, Middle, Maiden Surname) LVA BALDEL ပ permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke any injury or other traumatic Alfred Venicy/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 138 N. Culver Street, Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Owings Mills, MD Donation 5 Cher (Specify) Garrison Forest Veterans 4-14-2011 21. Si n 22. Name and Address of Facility Lie Funeral Home P.A. of 391to. Co. of Funeral Service License 9200 Liberty Road, Randallstown, MD 21133 rant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death End. Stage Dementia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? eral Director, After this certificate filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Dother (Specify) hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check ☐ Medical Examiner: On the basis of examination and/or investigation, it may opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MSky apamem in 29d. Date signed (Month, Day, Year) DOU57465 417/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltomore, ND ZIZOG 2835 Smith Rajapakse, M.D 5-203

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

APR 11

2011

32. Register's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ raz Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Koma Montgomery **QSHINGTON** ventist If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign curity Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F .0883 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Medical Examiner must be notified at **Funeral Director** Washington 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a nited Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No , or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced black Completed 16b. Kind of Business Industry Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 5Patcher traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ည t. Page 1 and 2 should be trment of Health and Mer rtant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sargent Rd. NE. #109 WOSH-1 *Malker* Slouse injury or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of h
Important: If ite
any injury or oth 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State andover Mil armony Memoria 4 ☐ Donation 5 ☐ Other (Specify) 420 H 22. Name and Address of Facility 21. Signature of Funeral Service License 23a. Part 1. Enter the insease, or complications that or used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Androvascular Discor Anterioscherenz disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any course immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence of as the burial-transit Due to (or as a consequence of) resulting in death) Last ttending physician Physician/Medical that the death certificate be IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🗷 No Month Year g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ oronary Anteny Disease Division of Vital Records, the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed Polmonary Hypertonson 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No NON STELL Wated my ocandial infa 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 \(\sum \) Yes 2 \(\frac{1}{4} \) No Other: မူ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Medical Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No death. within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

205 QUEENSBURY Rd Hyattsville KND 20781 31. Date filed (Month, Day, Year) APR 1 1 2011

ore uns who completed cause of death (Item 23a) (Type, Print)

only one)

29b. Signature and title of certifier

101852

29d, Date signed (Month, Dav, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Arthur Paul Williams 315 AM 04 0 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rossville Baltimore FRANKLIN Square Hospital Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min. **1**X□ M 2□ F 215-16-9257 Director 1924 March 13 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene, Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at once. 1 ☐ Yes 2√∑ No Director MD. Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9533 Powderhorn Lane 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ∑XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: à Specify: Uhite 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) District Manager 4-4 Verizon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chester Williams Thiel Louise ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Williams/ Son <u>1236 Delwood Ave. Hagerstown.</u> MD. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-12-11 4 Donation 5 Dother (Specify) Dulanev Valley Mem. Timonium. MD. 22. Name and Address of Facility
Ruck Towson Funeral Home. Inc. 21. Signature of Funeral Service License York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Embolism disease or condition resulting in death) FaT /Medical Due to (or as a consequence of). Examiner b. I Diovathic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit be execute Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. □Yes 2□No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Fracture 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 \textstyle certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 res 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred (does blown by wind 27. Manner of Death 28b. Time of 28c. Injury at Work? Division 5 ☐ Pending investigation Knocked onto ground by opening cardon 1 Natural after death.

I Director: Aid in by the fur 4-5-11 1 ☐ Yes 2 ☑ No 2 Accident Unknown 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Parkville At Home 9533 fowder Horn Lane 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) The Horts 1 069198 7,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR John V KottarthiL 9000 FAAnklin Square DR Ballo md 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Day 201^{Year} 9 7:40 Рм Milton Zavadil, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris Social Security Number 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Country) Maryland Nov 29 y Days Hours Min T928 216-28-0305 82 Yrs **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Timonium MDBaltimore 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? with t items 23a Funeral USA 21093 219 Eastspring Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 'natural", or Maryland 21215-0036 hours after _{Specify:} white 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. d other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the once. MD National Guard 5+ Col. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bessie Marie Bernard Milton Zavadil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 219 Eastspring Road; Timonium, MD 21093 wife <u>Doris P. Zavadil</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☑ remation 3 ☐ Removal from State 20c. Location - City or Town, State Timonium, MD Dulaney Valley Mem Gardens 4/14/2011 4 Donation Other (Specify) Signature of Fur eral Service Life 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or impury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the signed by the attending purpose as a signed for use as: IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 C Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 🔲 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, Division of Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DDA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident Hospital or Attending 5 Pending work?
1 Yes 2 🗌 No Investigation 6 Could not be 3
Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 TUN 31. Date filed (Month. Day, Year) State Registrar

X DHMH 17 Rev 7/2009

1107

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ march 201 Donald Delouie Brown Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hagerstown Washington Meritus Medical Center Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 № M 2 🗆 F Months Hours Min. Director 7/12/1934 Virginia 577-44-3251 76 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 🗌 No Washington <u>Maugansville</u> 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be. Funeral 13902 Weaver Ave. 21767 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ 2 No 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည N/A Annette McGuire 1 and 2 should but the strength of the strengt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Lee Brown / Spouse 3902 Weaver Ave., Maugansville, MD 21767 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory | Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 3/30/2011 Significant of Funeral Pervice L 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate an each line shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a as the burial-Physician/Medical Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 2 No the 9 Unknown P.O. I ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? by 2 1 No Records, 1 🗌 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) director examiner? 2 / No Inpatient 2 မ 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director; After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural work' 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer o 29d, Date signed (Month Day, Year)

OH7+1

State

31. Date filed (Month, Day, Year)

MAR 31

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 35 March 2011 Americo Anthony BRIGIDO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Loyalton Hagerstown Washington 6. Sex 1 ፟፟፝ M 2 ☐ F Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, Ye Aug. 20 Months Davs Hours Min. 88 **Director** Pennsylvania 186-16-6103 Usual Residence of Decedent 28a-f show Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits rector 1 🛚 Yes 2 🗆 No Maryland Washington Hagerstown ۵ 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Loyalton - 2009 Rosebank Way 21742 USA items ; within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give U U Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed Specify: Year or Dates. W.W. IIWhite other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 0 Construction (Union) Construction Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ည Peter Brigido Rose Gabello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Stephen Brigido - Son 20813 Emerald Drive, Hagerstown, Maryland 21742 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 9 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/2/2011 Old Forge Cemetery Old Forge, Pennsylvania 21. Signature of Funeral Service Lice is e 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, si_ian/ archopy disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of Exami attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence o Physician/Medical ensim P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Live Birth 2 Fetal death Day Month Year Pregnant at time of death ned by the a e detached f Part II. Other significant conditions contributing to death but not sesulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 \(\text{Yes} 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{6} \) Other (Specify 2 No assited မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) filled in by the funeral 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 1 Natural 28d. Describe how injury occurred injury 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho
To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and little of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CISEN MAIL MD 2031/Cappans

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Da

JH-8+1

gistrar's Signature

11-02497										
Craig H. Brown										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Craig H. Brown		Since State Registrar	ate of Maryla	*	artment of tificate of		and Me	ental Hy	_	eg. No.	201		1544	
Physicia	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year									3. Time			
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		Shady grove hospital		inber)		4b. City, Town Rockville		or Death	Montgomery					
Funeral		chas, green negation						s. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or				state or		
Director		212-82-5134	1XM 2F	51	Yrs		Days Ho	urs Min.	08/15	/1959	For	eign ^{Country)} Ne	w York	
		Usual Residence of Decedent					 							
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eath v	nue	1 Never Married 2 X M				es, specify Cu					White, etc			
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Baltimore, permit. Pages I ar Department of Hes Important: If ite		4 Donation 5 Other S		A1:	l Souls	Cemete	ery	4/6/	2011	Geri	nantow	m, Ma	ryland	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural?, or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Funeral Service	Licensee		10	ame and Add East I ithers	ess of Fac Deer	Park _a I	ol Fur gjye	ieral	Home			
Physician	\dashv	23a. Part I. Enter the disease, or	complications hat ca	aused the death.	Do not enter t	TENETS! ne mode of dyi	ng, such a	s cardiac or	respiratory an	rest, shock	, or heart		imate Interval	
/Medical		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a. Atl	eroscle		Cardiov	ascul	ar Di	sease			Betwe	en Onset and Death	
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physicinpletely filled in by the funeral director, page 2 should be detached for use as the burn		IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, o	outcome of pregr		tal death	3 Fctc	pic pregnan	cv		Date of delivionth	ery Day	Year	
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Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be dead	Be	25. Was case referred to medica examiner?		npatient 2	EB/Outpationt			th (Check or Nursing		Residenc	e 6 Ot	her:		
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/iSi	fica		stigation 28e. Place	of Injury - At ho	ome, farm, stree	et, factory, offic	e building,	etc. 2			Number or	Rural Route	Number, City	
Divisior ospital or Attend hours after death neral Director:	Certification:	Odicide =	rmined (Specify)						or Town,	State)			1	
e Hos		29a. Certifier (Check only 1 Certifying P	hysician: To the bes	t of my knowledg	ge, death occur	red at the time	, date and	place, and o	lue to the cau	se(s) and	manner as s	tated	•)	
To the Ho within 24 To the For completel	Medical		miner: On the basis of and manner s	ated.	nd/or investigat				ule time, date		te signed (i			
	2	29b. Signature and title of certific	, 1	1			ense numb C.M.E.	rei			1, 2011	worm, Day,	i eaij	
	ļ	mun	11	o of death and	/ (J., 11., L.			J	.,			
L-PEND			Assistant Medic	al Examiner	111 Pen	n Street, B	altimore	, MD 212	01					
St Regist	ate rar	31. Date filed (Month, Day Year)	2011 An	gistrar's Signat	· par						200			
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month 26 2011 **Physician** 1:15P March Paul Thomas Birch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Dorchester Secretary 103 Main Street 8. Date of Birth (Month, Day, Year) 9. Birthpiace (Sur Country)
April 23,1919 Maryland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 91 Director 031-03-1180 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland Dorchester Secretary death with the 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21664 103 Main Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black White, etc. 72 hours after 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 X Widowed 4 □ Divorced 'natural", Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Local should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Wastewater Manager Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Watson Birch ဂ္ 0scar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is any Injury or other trausone. O. Box 236, Secretary, Maryland 21664 Geraldine Larrimore/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State Our Lady Of Good Counsel 4/1/2011 Secretary, MAryland 4 ☐ Donation → ☐ Other (Specify) 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207 21. Sign ur of Funeral Service L 106 Main Street, East New Market, MD 21631 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between ega. Part . Enter the disease, of shock, or heart failure. List Onset and Death Demerks Immediate Cause (Final Starz **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): ord. Nacular directe Examiner Arteriose (ente Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed' 2 / No-1 ☐ Yes 2 ☑ No 1 ☐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending ours after death.
neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 24 hours a 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 47924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAURRIDGE MD 216/3 842N 503 NIONAAN 58 THANWY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 29

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 210 Bolden Kathie Lvnn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-RMC Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 M 2 DF Months Days Hours Min Feb 22 ¹⁷1955 215-68-6273 Director 56 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mantal Hygiene. Important If item 27 is marked other than "natural" ~ *** any injury or other traumatic event *** 10b. County 10a. State 10c. City, Town or Location 10d Inside City Limits Director MD Frostburg Allegany 1 KYes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 17214 Beechers Avenue 21532 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 ☐ Never Married 2 🗷 Married 1 ☐ Yes 2 ☐ No Specify: Specify. white 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cynthia (Deter) Ziler Robert F. Cosgrove 19a. Informant's Name/Relationship (*Type, Print*) **John Bolden** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17214 Beechers Avenue Frostburg MD 21532 husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Sunset Memorial Park 4/4/2011 Cumberland MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name an Scarpelli Fullieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and 1 in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniurv work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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W.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 29 Day 2011 Year Physician/ 8:45 P.M Leon Albert Creek Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington 14543 Maple Ridge Rd Hancock 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number . Age (In yrs. last birthday) **Funeral** 1 🙀 M 2 🗆 F May 24, 1946 Mary land 64 220-46-7369 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State **Funeral Director** 1 Yes 2 X No Washington Hancock Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21750 U.S.A 14543 Maple Ridge Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Self-employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Albert G. Creek Dolores Younker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14543 Maple Ridge Rd. Hancock, Md. Beverly A. Creek 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 31, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Smithsburg, Md. 2011 22. Name and Address of Facility Smature of uneral Service Licenses 141 W. Main St. Grove Funeral Home Hancock, Md. 21750-0368 Moo260 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Plumician chronic obstructive disease rears disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Dilleta (orași a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 1 Yes 2 No s been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an obstructive cate has b autopsv performed' 1 Yes 2 No ours after death.

Jeral Director: After this certificate filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral D Hospital Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 29b. Signature and title of certifier 29c. License number anthra Kuther - Sand, D D47451 30. Name and address of person who completed cause of death (Item 23a) (Type, Print shing ton County Cynthia Kuther Sands, no Hospice of Washing ton This orst Nagerstown 31. Date filed (Month, Day, Year)

State Registrar 32. Fegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Day Physician/ Month Year рΜ Anthony Francis Colucci 2011 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth Feb. 27, Year 1983 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 □ F 28 166-70-5932 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State items 23a or 28a-f sho ner must be notified at within 72 hours after death with the Maryland Director MD 1 Yes 2 M No Montgomery Chevy Chase 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4819 Leland Street 20815 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces? Black White, etc. 1 Never Married 2 Married Completed by Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 alth and Mental Hygiene.
127 is marked other than "r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Author Writing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frank Anthony Colucci Asimina Maria Coroneos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Asimina Maria Coroneos/Mother 4819 Leland Street, Chevy Chase, MD 20815 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ŏ 12 Burial A Cremation 3 Ammoval from State March 28 Department of Important: If any injury or 4 Donation 5 A Other (Specify), Fort Lincoln Cemetery Brentwood, Maryland 21. Signature of Furter I enfoce Lie ins Funeral Home Blvd. W., Silver 23a. Part 1. Enter the disease, or complications that cau ed the death. Do not enter Approximate Interval Between shock, or heart failure. List only one cause on ea and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) mp as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of injuly that initiated events resulting in death) Last and Due to (or as a consequence of) 3 the attending physician Physician/Medical 8 IF FEMALE: use . If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months? ò per (specify) Pregnant at time of death detached 9 Unknown s contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? To Be Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has Polucci, Anthony performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No ipleted filled in by the funeral director, **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at Certificate: 24 hours after death.
Funeral Director: After t 1 Natural
2 Acciden 5 Pending 23 ☐ Accident Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street an City or Town, State) determined Darki Garage Medical Certifying Physician: To the best of my knowledge, death occured at the fifte, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Retrifying Note: Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the only one) To the 29c. License number d title 29b. Signature a ess of person who completed cause Paul Muench, MD son who completed cause of death (Item 23a) (Type, Print) 30. Name an Jeff f 8600 Old Gerogetown Road, Bethesda, MD 20814 Registrar's Signature State 2.8 2011 Registrar

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State of Maryland / Department of Health and Mental HygieRe Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:15 рм Chester Lee Callander 2011 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Oregon 1 🗓 M 2 🗆 F Months Days Hours Min. M9472879917 543-09-2380 93 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 u.s.A. 629 Whitingham Drive 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No 1942 −
If Yes, Give
Year or Dates.
1965 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) U.S. Treasury Economist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louise Kulisch Pearlie W. Callander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 629 Whitingham Drive, Silver Spring, Maryland 20904 Barbara L. Callander - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State Lincoln Crematory 04/01/2011 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Europeal Service Licensee 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Weeks Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Examine Due to (or as a consequence of) attending physician an for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a ld be detached f 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Old Stroke with Left Hemiparesis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Seizure Disorder Jas autopsy death? After this certificate I Hupothuroidism 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔼 No Hospital Other: ည 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) ne Hospital or Attending Plin 24 hours after death.

he Funeral Director: After the fulleted filled in by the funera 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, npleted filled in by determined 🔼 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Barbara Alepanich, ESM, MD D0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RSM, MD, 1500 Forest Glen Road, Silver Spring, Maryland 20910 Barbara Supanich, 31. Date filed (Month, Day, Year) Registrar's Signatur State MAR 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician/ 2011 March 8:47 A Crisp <u>Pearline</u> Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Alfred House 8. Date of Birth
(Month, Day, Year)
Nov. 25, 1925 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏋 F Months Days Hours Min. South Carolina **Director** 85 247-32-7191 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Na. Also. 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Silver Spring Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20906 United States 4 Broomall Court 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Completed American 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Laundry Worker Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mary Davis unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Capitol Heights, Maryland 20743 Devarda Crisp Jones - Daughter 1108 Booth Lane 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Maryland Veterans 30, 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State March 4 ☐ Donation 5 ☐ Other (Specify) 2011 Cheltenham, Maryland Cemetery 22. Name and Address of Facility Stewart Funeral Home, Inc. nature of Fun Service Licen 4001 Benning Road NE Washington, DC 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Cerebravascular Artery Disease Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of, ng physiclan and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Arteriosclerosis Generalized that initiated events resulting in death) Last Due to (or as a consequence of) attending physiclan I for use as the buria Physician/Medical Diabetes Mellitus Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year Pregnant at time of death detached the Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be del by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 🔀 death? 1 ☐ Yes 2 ☐ No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) examiner? 10 Hospital Other: 1 🗀 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 XNatural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 7 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe Ohe March 24, 2011 D25410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Oliver J. Lawless MD FACR

31. Date filed (Month, Day, Year)

MAR 2 9 2011

18111 Prince Philip Drive, Suite 310

208832

Olney, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month of 243 Cook Corey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's **Examiner** Forest Heights 5814 Ottawa Street . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 XXM 2 □ F 54 1272071956 579-74-4638 Louisiana **Director** Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland| Prince George's 1 Yes 2 No Forest Heights 10g. Citizen of What Country? Funeral 5814 Ottawa Street 20745 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Completed 3 Widowed 4 Noivorced Black Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) the Auto Mechanic Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur William Cook Mary Alice 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kifri Edwards / Daughter 329 Devon Drive Chestertown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4/3/2011 4 Donation 5 Other (Specify) Kalas Crematory Edgewater, Maryland Fune Service Cicensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatu 6160 Oxon Hill Rd. Ōxon Hill, Maryland 20745 Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Arteriosc disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Cisease or iinjury Due to (or as a consequence of) attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available within 24 hours after death.

To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2. autopsy death? 1 ☐ Yes 2 ☐ No 21 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DCA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Dav. Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AN O 3001 Hos 31. Date filed (Month, Day, Year) MAR 2 9 2011 Registrar

State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year MARCH Α. Carson, Sr. 201 <u>Tyrone</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death <u>Doctor's Community</u> Hospital Prince Georges Lanham 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Min. 08/16/1952 Director Washington, DC 579-70-8755 Usual Residence of Deceden Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Me lical Examiner must be notified at 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 ₹ Yes 2 □ No MD Capitol Heights Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>4721 Heath Street</u> 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by TYRONG Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. ?7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 Heavy Machine Mechanic Washington Gas Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Paul Carson, Sr. Cleo Pryor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Capitol Heights, MD <u> Gladys Y. Carson/wife</u> 4721 Heath Street 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 103/29/2011 Brentwood, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Montgomey Cheat Claim. 3401 Bladensburg Road Bren 23a. Part 1. Ever the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Brentwood, MD Immediate Cause (Final Onset and Death ₽hysician/ disease or condition resulting in death) Hepatic Failure Medical Examiner Due to (or as a consequence of) Massive Ascities Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and sician and burial-trans Congestive Heart Failure that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month 5 Other (specify) Dav Year Pregnant at time of death hed g Unknown Ö ed by t detach signed I Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🖰 No Hospital: ၉ 1 Mail Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🖺 Natural 5 \square Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and tipe of certifing 29d. Date signed (Month. Day, Year) MDD23044 03/24/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Greenbelt, MD 20770 Suite 309 Greenway Ctr. Dr Said Daee. MD Date filed (Month, Day, Year) r's Signature State MAR 2 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 Day 14 AM Physician/ Carrick, Sr. 2011 L. Raymond Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico If Under 1 8. Date of Birth 9. Birthplace (State or Foreign If Under **Funeral** Months 1 🔀 M 2 🗆 F (Month Day, Year) 1-27-1939 Maryland Yrs. Director 72 213-36-2006 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location at 10a. State 10b. County filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 X No Salisbury MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21804 6116 Ruth Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Completed by € Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Printing Company Quality Control Manager 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Richards Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 Wyman Drive, Salisbury, Maryland 21804 Raymond L. Carrick, Jr. - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3-28-2011 Salisbury, Maryland Parsons Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Bounds Funeral Home Main Street, Salisbury, Maryland 21804 705 E. Approximate Interval Between Onset and Death 23a. Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cade on each line. Immediate Cause (Final DISPLASE CHRONIC Physician/ monan disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence bij): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending physic for use as the b IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a detached 1 Unknown g Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 46 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 D Nursing Home 5 D Residence 64 ၉ 1 Inpatient 2 I ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 27. Mapper of Death 28d. Describe how injury accurred 5 Pending Natural work' 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058410 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 egistrar's Signatu State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 28, 201/1 12:10 AM Richard Chase Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Hospice House Prince Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Days (Month, Day, Year) January 14, 1944 1 🔀 M 2 🗆 F **Director** 67 213-42-8531 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s idical Examiner must be notified 1 Yes 2 X No Chesapeake Beach MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3935 Gordon Stinnett Avenue 20732 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced Year or Dates Black event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Construction Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 Charlotte Freeland Cornelius Chase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3935 Gordon Stinnett Avenue, Chesapeake Beach, MD 20732 Majetta Chase - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗖 Removal from State Southern Mem. Gardens | April 5, 2011 Dunkirk, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Dla 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Pregnant at time of death 9 Unknown been signed by t should be detack significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? perform Yes Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 မ 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending 1 Tes 2 🗌 No ☐ Acciden ☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one 29b. Signature and 29d. Date signed (Month, Day, Year) ddress of person who completed cause of death (Item 23a) (Type, Print) 106 31. Date filed (Month State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1.05 AM Physician March 2011)avid owning /Medical 4b. City, Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 X M 2 D F 21 430-77-3073 Feb.10,1990 Arkansas Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location show Examiner must be notified at 1 Yes 2 No Director 28a-f Knoxville Maryland Washington 10g. Citizen of What Country? 10f. Zip-Code 10e, Street and Number ō Pages 1 and 2 should be filed within 72 hours after death with U.S.A. 19326 Keep Tryst Road 21758 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ½ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2√ No ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: Specify: White ģ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry of Health and Mental Hygiene. Item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lolivy or other traumatic event once. Be Joanna L. Johnson James F. Downing, II 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19326 Keep Tryst Road, Knoxville, Maryland 21758 James F. Downing, II/father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 03/31/2011 | Frederick, Maryland Service Licens 22. Name and Address of Facility Bast-Stauffer Funeral Home 21. Signature of Funer 7606 Old National Pike, Boonsboro, Maryland 21713 Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or co heart failure. List only one cause on each Immediate Cause (Final acuté **Physician** respirator disease or condition resulting in death) /Medical Due to (or as a conse luence of) Examiner Influenza Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events quantially list conditions, Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectonic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 No filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury М 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funeral L Hospital 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 March 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Voonin 600 North Wolfe St, Baltimore, MD, 21287 Minh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 4:29 a.m Alberta Virginia Dunn March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 □ M 2 🗓 F Months Days Hours July 20. 1926 84 Director 218-20-1245 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director 1 🗌 Yes 2 🗓 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 10332 Parkman Road 20903 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes Yes, Give Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: White. Completed 3 Widowed 4 Divorced Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) House Wife Homemaker Be int. Page 1 and 2 shou...
whent of Health and Menu.
If item 27 is marked out 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Murtle Virginia Burch Wilbur Crawford Hood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10332 Parkman Road, Silver Spring. Maryland 20903 Raymond Eugene Dunn - Spouse Baltimore, Important: If iten any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Olivet Cemetery 103/30/2011 Frederick, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service License Katrina 11800 New Hampshire Ave.. Silver Spring, MD 20904 MGWOON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIAC Physician/ disease or condition Medical resulting in death) Examiner HEMORILHACIC Sequentially list conditions, Examine GASTRUINTESTINAL BLEET if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ivision or vital וייבייייי) or Attending Physician. The law requires that the death certificate be executed of the relation of the strength. attending physician and for use as the burial-transit that initiated events resulting in death) Last MYOCARDIAL INFARCTION Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCER WITH 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons pade 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 8 examiner? Hospital Other: 2 110 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at s after death.

I Director: After to in by the funeral 28d. Describe how injury occurred work? 1 Yes 2 No Natural (Month, Day, Year) 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined To the Hospital within 24 hours a To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier 24/201 MMM of death (Item 23a), (Type, Print) WASHINGTON ADVENTUST HOSP, TAKOMA PANK SHAMIM State 28 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 2011 2:00A M Susie F. Dove Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arunde1 Annapolis 52 Belle Ct. If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Hours 1 □ M 2 🛣 F May 31 Year 919 Maryland 91 Yrs Director 219-16-0059 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertalet Hygiene. Important if fire 27 is marked other tran "natural", or items 23a or 28a-f show any injury or other traumatic event. the Mariani Fire. 10b County 10c. City, Town or Location Director 1 Yes 2X No Marvland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21401 52 Belle Ct. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Completed by 1 ☐ Yes 2 XNo Specify: Specify: Black 3

Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland 12th 0 Custodian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie Parker William Johnson 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 Severn Island Ct. Annapolis, Md. Celeste Dove(Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20bHPlact of Disobattion (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Md. Memorial Gardens 3 - 28 - 11WMJame Rease of Politisons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sarcoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 5 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Dicho Be (25. Was case reference examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 Like Other: ျှ ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 the signed by the peen this certificate has within 24 hours after death.

To the Funeral Director: After

Baltimore, Maryland 21215-0036

State

Registrar

Medical

29a. Certifier

29b. Signature

30. Name and a

only one

who completed cause of death (Item 23a) (Type, Print)

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Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Physician/ 8:45 AM 201 Curtis Leroy Dowtin, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Doctors Community Hospital Lanham If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Days 01 18 Hours Min Country) 74 1937 Director 249-50-8386 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d, Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c, City, Town or Location Director 1 X Yes 2 □ No MD Cheverly Prince Georges 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral United States 6106 Osborn Road 20785 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Black Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Family Service Counselor Death Care Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Onnie Seppie Tolbert James Daniel Dowtin, Sr. permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat once, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6106 Osborn Road Cheverly, MD 20785 Loree Dowtin/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Crematory 03/30/2011 Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Furieral Service License 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardiac Arrhythmia Medical Due to (or as a consequence of) Examiner Acute Respiratory Failure Sequentially list conditions Examine Disk to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Sepsis as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death ☐ Pregnam of Unknown Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Anoxic Encephalopathy 24b. Were autopsy findings available 24a. Was an Decubitus Ulcer prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify) 2X No 2 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 🔄 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital within 24 hours a To the Funeral D

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State

Medical

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 2 9 2011

Fisehatsion G. Mehari, MD

release, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D0064478

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

12700 Goodloes Promise Dr. Bowie, MD 20720

29d. Date signed (Month, Day, Year)

03/23/2011

/Medica Examine To the Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records. P.O. Box 68760. attending physician for use as the buria cate has I within 24 hours a To the Funeral C

Physician

/Medical

Examiner

Funeral

Director

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Familier must be a

Pages 1 and 2 should be tilt tment of Health and Mental H-tant; if Item 27 is marked oth jury or other traumatic even

Directo

Funeral

Completed by

MD

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Department of Important; If It eny Injury or one		1 Denation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Fai	nily		and Address of F	acilityW . H .	2011 Vir Bacon Fun ashington	eral Hon	ne, Inc.
The law requires that the death certificate be executed and a seen signed by the attending physician and a seen signed by the attending physician and a seen signed by the attending physician and a seen signed by the action of the seen signed and a seen signed as the burial-transit and a seen signed as the burial-transit and a seen signed as the secuted as the secured as the secuted as the secuted as the secuted as the secured as the secu		23a. Pari. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that cause the deare cause on each line. a. Certely Due to (or as a conse	o Vo	non	de of dying, suc	h as cardiac or re	Services,		Approximate Interval Between Onset and Death
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):								
	ysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1								
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	Complet	24a. Was an autopsy performed? 1								
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To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; Macdical Certification: To Be	tlon: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 2 [28a. Date of Injury (Month, Day Year)	28b. Ti		OOA Other: 4{ 28c. Injury at Work? 1 □ Yes	280	5 Residence		HVING
	Sertifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, far	m, street, factory, office 28f. Location (Str. City or Town,				eet and Number or Rural Route Number, State)	
o nospir 24 hour 18 Funera setely fille	Medical		sician: To the best of my kr ner: On the basis of examinand manner stated.							
withir To th comp	W	29b. Signature and title of certifier Rhymer	J. Nin	ole	2 2	D 45	285		rch 23	

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

5. paris

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilkinson J. Ninala 344 University Blvd. West Silver Spring, Maryland 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MPACH Physician/ 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SAUSHU Acom ic Medical REGIONAL TENIN SULA 4 Hrs. 1 Year If Under or Foreign 8. Date of Birth 9. Birthplace (State 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF Month Day, Months Days Hours Min. Director 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menth Hygene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medio-I Examiner must be notified at 10c. City Town or Location Funeral Director 1 X Yes 2 No 10f. Zip C Street and Numb 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry ite. DO NOT use retirad) College (1-4 or 5+) 9 N Be 17. Father's Name (First, Middle, Last) ဂ္ Informant's Name/Relationship 20a. Method of Disposition 20b. Place of Disposition (Name of ocation - City or Town, State 1 🥦 Burial 2 🗌 Cremation 3 🗀 Removal from State Donation 5 Other (Specify) Name and Address of Facility Signature of Funeral Service Licensee of 23a, Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ - I Wester Hemon week Medical resulting in death) Due to (or as a consequence of): Examiner Jegeness Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 1 Yes 2 signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 Probably 4 Unknown 1 Yes 2X No been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 has 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) HOS5619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DO 32. Registrar's Signature State 28 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JAN Physician/ Day 2011 1:50 P M 31 KHEAVEN EDWARDS Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner BETHESDA MONTGOMERY NATIONAL NAVAL MEDICAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 29 (Month, Day, JAN 31 1 🗆 M 2 🗆 F Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10d. Inside City Limits 10c. City. Town or Location Medical Examiner must be notified at Director 1 X Yes 2 ☐ No PRINCE GEORGE'S MD UPPER MARLBORO 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20772 UNITED STATES 5304 CHARLES HILL BOULEVARD 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ō à Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 K No Specify: "natural" Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) the N/A N/A n other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H litem 27 is marked ot rother traumatic ever ပ KARONDA DOMONIC BAXTER KEVIN ANTHONY EDWARDS e 1 and 2 should be of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 5304 CHARLES HILL BOULEVARD UPPER MARLBORO MD 20772 KARONDA EDWARDS/MOTHER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) 21. Signature of F 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition EXTREME PREMATURITY Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of that the death certificate be executed the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy pade performed' death? certificate l 2 🔀 N 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔀 No Other: 1 Minpatient 2 ER/Outpatient 3 DOA 1 Yes ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending 5 Pending injury work' Natural s after death. 1 🗌 Yes 2 🗌 No Accident Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours a Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗋 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18 0101245138 (VA) 2011

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

of Vital

Division

MC

egistrar's Signature

NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

CENTER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADIMORA

CHINENYE 31. Date filed (Month, Da

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 182011 4:15 AM March Richard Frank Freund Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 8000 Maple Avenue Takoma Park If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. July 23 New Jersey **1**939 Director 151-30-8222 71 Usual Residence of Decedent Default. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🗓 No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8000 Maple Avenue 20912 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Caucasian 1 ☐ Yes 2X No Specify 3 Divorced Year or Dates.1958-61 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) meteorologist National Weather Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rick Freund Margaret Bosch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly M.Q. Freund, spouse 8000 Maple Avenue, Takoma Park, Maryland 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parklawn Memorial Gardens 3/25/2011 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licenses MO1102 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 6 months Pulmonary Fibrosis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has performe death? Yes 2 X No 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 Tes 2 💢 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA s after death.
al Director: After the 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, pleted filled in by determined City or Town, State) within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 000143-MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Hubert J. Alpert,
31. Date filed (Month, Day, Year)

MAR 25

5410 Rockledge Drive Suite 401, Bethesda, Maryland 20817

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia										Month		Day Year	3. Time of Death 7:30 A M	
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shoult and I is ma		19a. Informant's Na	ame/Relationship	(Type, Print)		19b. Mailir	ng Addres	ss (Street a	and Number or R	ural Route Nur	nber, City	or Town, State, Zi	p Code)	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee MONG3 22. Name and Address of Facility Edward Sagel Funeral Direction Inc. 1091 Rockville Pike Rockville, MD, 20852												
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To th withii To th		29b. Signature and		11-1				c. License				Date signed (Mont		
10		1 KK	12-11,	My and	D.			D144	40		l M	March 21	, 2011	
		30. Name and addre	ess of person wi	no completed cause of c	eath (Iten	n 23a) (Type, P	rint)							
		Jerome J	Schna		161	New Ha	mpsh	ire A	Ave. sui	te 201	Silv	er sprin	g, MD 20904	
State Registra	-	31. Date filed (Monti	2.5 201	32. Registr	ars Signa	ture	المدا							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Peter Month March Flaherty 13, 4:22 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day,) Dec 20, 9. Birthplace (State or Foreign **Funeral** Year 1927 1 🕱 M 2 🗆 F Months Days Hours 577-44-4302 Ireland Director 83 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 8605 Wandering Box Trail, 21113 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give þ 1 ☐ Never Married 2 🏲 Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. 1 and 2 should be filed with f Health and Mental Hygien item 27 Is marked other th Director of Bell Services Mayflower Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Martin Faherty Mary Clancy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8605 Wandering Box Trail, #204, Odenton, MD 21113 Mary T. Flaherty/Wife fnjury or other item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State March 17 2011 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signat e Funeral Service Licen Pame and Address of Facility ins Funeral Home Inc. 00 University Blvd. W., Silver Spring, MD 20901 Fra: 500 23a. Part 1. Enter the disease, or compli ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each live Immediate Cause (Final disease or condition resulting in death) Physician/ Cosper afor Tarlene Medical Due to (or as a consequence of): Examiner actmonerial usarasanoid suspense and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of 5 burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical that the death certificate be Box 68760 the as use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Dav 5 Other (specify) detached g Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to be det þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Quatremia 24a. Was an seteus 10 performed 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referr Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Npatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) and feel after a large due 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred PH tu Certificate: 1 Natural 2 Accident 5 \square Pending before len 1 Yes 2 No within 24 hours after death.
To the Funeral Director, A completed filled in by the f Investigation Lo fon (Street and Number or Rural Route Number, City or Town, State) \$605 Wandering Birk Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide At home farm, street, factory, office 28e. Place of Injury A building, etc. (Sp determined at To the Hospital Irail Medical 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4337 2001 AAme of person who completed cause of death (Item 23a) (Type, Print) Dolin or. Judy 31. Date filed (Month, Day, Year) State MAR 25 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 Elizabeth Finlayson March 4:45 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Sunrise Assisted Living Annapolis 9. Birthplace (State or Foreign Country) DISTFICT of Columbia If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) une 09,1916 Months Min. 1 □ M 2 👿 F 94 213-68-7955 Yrs. **Director** June Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Annapolis Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 USA 800 Bestgate Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Congressional Aide Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of
any injury or other traumatic eve ဥ Annie E. Lee Charles Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37335 Waterside Circle Ocean View, Delaware 19970 Steven Finlayson / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State unk Date 20b. Place of Disposition of other place)
Arlington National
Cemetery 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington, VA 21. Signature of Funeral Service Lidenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death acchi Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 E FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death been signed by the a should be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an page 2 s certificate Yes 2 No **Division of Vital** 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: sistec 1 🗌 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After 5 Pending Natural 2 🗆 No 24 hours after death. Funeral Director: Al 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Hospital Medical 29a. Certifie Certifying Phy si**∉ian:** To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying N within 2. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) completed cause of death (Item 23a) (Type Print) Name and address of person who 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 5 201 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Year Edward Fountain, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City Town or Location of Death 4c. County of Death Poninsula Regional marical 8. Date of Birth OCt. 17, If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 🗆 F Months Min. Hours 215-62-0633 Delaware 1953 **Director** Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Princess Anne Maryland Somerset 10g. Citizen of What Country? items 23a or ner must be n 10e, Street and Number 10f. Zip Code Funeral 11258 Old Princess Anne Road 21853 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 19 4 - 76
If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Transit Service Bus Driver 11th æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
traumatic ever ၉ Willie Davis Inez Fountain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherie-Fontaine-DeShields/daughter 9010 Jersey Road, Salisbury, Maryland 21801 if Health a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ± 5 1 X Burial 2 Cremation 3 Removal from State Department or Important: If any injury or Springhill Mem. Gdns 04/02/2011 Hebron, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD Jolley Memorial Chapel 21801 23a. Part 1. Enter the disease, or complications/triat caused the flath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause n each line. Immediate Cause (Final Physician/ disease or condition resulting in death) anwealton Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Jause (Disease of finjuly that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) Year cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 No 1 Yes 25. Was case referred to medical in by the funeral director, 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ဂ္ npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director; After the time of the price of the p Natural injury 5 Pendina 2 Accident M 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge death distributions: data and plane, and due to the names(s) and marrier as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) B63199 3/23/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 714 EASTERN SHORE DR. SALISBURY NO. 21804. VOHRA 910 YOGES H

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAR 28

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joselito March 23,2019 Garcia 1700 Mendez Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Montgomery **Examiner** Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Sex 1 M 2 D F 9. Birthplace (State or Foreign 579-21-4762 Hours Month, Pay 1/29/971 39 Gwatemala Director 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Montgomery Silver Spring 1 🗆 Yes 2 🕇 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2512 Forest Glen Road 20910 Guatemala 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 within 72 hours after 1X Yes 2□No Specify: Guatemalan Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Baker Bakery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hugo Armando Mendez Alberta Garcia Gonzalez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugo Rene Mendez/brother 2512 Forest Glen Road Silver Spring, Md20910 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Asuncion - City or Town, State cemetery, crematory or other place) Cemeterio Nuevo Municipal 1 Burial 2 Cremation 3 Removal from State 4/2/2011 4 Donation 5 Other (Specify) Jutiapa, Guatemala 21. Signary Funeral Service Lansee PHILIPODS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Respiratory failure Medical resulting in death) Due to (or as a consequence of): Examiner Obstructive sleep apnea Sequentially list conditions, if any leading to immediate Due to (or as a consequence of if any loading to immedicause. Enter Underlying sician ca. e burial-trensit that the death certificate be executed Cause (Disease or iinjury that initiated events Pneumonia Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, Hospital or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) After this 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending injury n 24 hours after death.

e Funeral Director; A bleted filled in by the fu Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie pleted 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 24

To the F

comple only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 24, 2011 D00826 harina 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Silver Spring, Md Kshama Garq 31. Date filed (Month, Day, Year) 37. Registrar's Signature State

Registrar

MAR 28 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Goldman March 21, Day 2011 Physician/ Rosalie 930 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Chevy Chase If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Country A **Funeral** Days Hours 1 □ M 2 🔏 F o*67257*4925 85 Director |213-58-7497 Usual Residence of Decedent 10d. Inside City Limits items 23a or 28a-f shov 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 🔀 Yes 2 □ No Chevy Chase MD Montgomery permit. Page 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 2! any injury or other traumatic event, the Medical Examiner must be not once. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20815 5555 Friendship Blvd #407 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 【☐ No 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3X☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Secretary (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Private 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ida Bishow Louis Lipsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 226 Blaze Climber Way Rockville MD 20850 Philip Goldman - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a, Method of Disposition Date King Dayid Memorial Gardens 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/23/2011 Falls Church, VA 21. Signature of Funeral Service Licensee Edward Bage Funeral Direction Inc 1091 Rockville Pike Rockville MD 20852 M01163 23a. Part First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 100 set and 1 sth Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant a 9 Unknown Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Atrial Fibrillation Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed?

1 Yes 2 X No 1 ☐ Yes 2 ☐ No No tre recommend after death.

To the Funeral Director. After this certific: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home SX Residence 6 Other (Specify) 2X No ဂ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 🖔 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifie D24571 22 March 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jay Weiner MD 10605 Concord Street Kensington MD 20895

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . Day 20<u>11</u> Physician/ March 22, Galperin Mark 1150 AM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Rockville Montgomery 12630 Veirs Mill Road #1220 Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Funeral Days Hours Min. 0370171942 Russia **Director** 214-63-4020 69 Usual Residence of Decedent shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Montgomery Rockville 1 Yes 2 No or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 20853 United States 12630 Veirs Mill Road #1220 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Constructon Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Definit. Page 1 and 2 should be Department of Heath and Ment Important: If item 27 is marke any injury or other traumatic. Solomon Galperin Maria Gluzman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mikhail Galperin - son 12630 Veirs Mill Road #1220 Rockville MD 20853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkiawn Memorial Park 03/24/2011 Rockville, MD 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Edward Sage | Funeral Direction Inc 1091 RockVIIIe Pike RockVIIIe MD 20852 M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Metastatic Gastric Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Pregnant at time of death Month Year Day 5 Other (specify) 2 No detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate Yes 2X No 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certifical eted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5X Residence 6 \square Other (Specify) 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 \square Pending injury work 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pleted filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner. On the basis of examination areas in the state of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2.
To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 23, 2011 D35046 n

Registrar
DHMH 17 Rev 7/2009

State

Ruth He MD. 3800 Reservoir Road NW Washington DC 20057

32 Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 25 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Joy Alma HEIL March 24 6:30 p. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Sept. 3, 1918 Months Hours 1 M 2 X F 92 Sountry) Marvland Yrs 214-09-5450 Director Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? event, the Medical Examiner must be 23a Funeral 954 Chestnut Street 21740 USA items 2 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 1 Never Married 2 Married ģ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Specify. white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) clothing mfg. seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Martin Luther Drenner Anna Elizabeth Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Judy Hebb - daughter 11531 Englewood Rd., Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place)
Mountain View Cem. 3/28/2011 Sharpsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) any inj once. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?
1 ☐ Yes 2 ☐ No Po Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown hed 9 \ Unknown To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ပ္ 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🖆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier D0055994 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

WH-2

32. Pigistrar's Signature

Campus Rd. Hagarstown, Md. 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2011 KATHLEEN MARIE HESS 12:45 AM March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick 5. Social Security Number 8. Date of Birth (Month, Day, Year) Nov • 15,1927 **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Linder 24 Hrs. 9. Birthplace (State or Foreign Days 1 □ M 2 🕱 F Hours 83 **Director** 266-32-2874 Yrs Nov. Florida Usual Residence of Decedent Show should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD Montgomery Rockville 1 Yes 2 No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 209A "natural", or items 23a Funeral 14401 Traville Gardens Circle, Apt 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes If Yes, Give 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Montgomery County life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School System School Bus Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည Roland D. Freeman Frances Richardson and lisi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Christopher L. Hess (Son) 5789 Morland Drive North, Adamstown, MD 21710 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan
Crematory 1 Durial 2 X Cremation 3 Removal from State Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee Devol Funeral Home, 10 East Deer Park Drive, IRACIA. M01117 Gaithersburg, MD 20877 MUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner ed by the attending physician and detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Box (23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown P.O. s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy page 2 performed? Yes 2 No this certificate Be (funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ျှ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28c. Injury at 28b. Time of After 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? Accident 2 No Investigation within 24 hours after death

To the Funeral Director: Suicide 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number 29d. Data signed (Month, Day, Year) 3911L QQW e of death (Item 23a) (Type, Print) Frederick, mo 400 W THIST Dlanch 2170 Registrar's Signature State MAR 25 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan		nt of Health and te of Death		ene g.mo.0	1572	
	Physici /Medio		1. Decedent's Name (First, Middle, Las Snivlee 1	turs			2. Date of Death	17 2011	3. Time of Death 945 Am	
	Examir Funeral Director	ier	4a Facility Name (If not institution, give 10 10 M W U U I E) 5. Social Security Number 6. Security Number 11	& Nursing 1	tome	Town, or Location of Dea CULUI II or 1 Year If Under 24 Hr Days Hours Min	s. 8. Date of Birth	Year) Country	e (State of Foreign	
	Maryland f show	ōr	Usual Residence of Decedent 10a. State 10b. County		ty, Town or Location	Brookvi	110	10d.	. Inside City Limits 1X Yes 2 No	
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at	with the Part of 28a-	Director	MD Mont 10e. Street and Number	gomery	10f. Z	p Code		g. Citizen of What Country	??	
	urs after death v	by Funeral	2905 Vandever S 11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	t. 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🖸 No If Yes, Give Year or Dates:	13. Was Dec If Yes, sp	20833 edent of Hispanic Origin? edity Cuban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	USA 14. Race - American Black, White, etc		
Maryland 21215-0036	vithin 72 hounder.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0·12)		life. DO NOT	ork done during most of w use retired)		16b. Kind of Business/Indus	stry	
and 21	be filed water Hygie of other to	Be	12 17. Father's Name (First, Middle, Last)		<u> </u>	18. Mother's N	ame (First, Middle, M		on	
laryla	2 should and Men is marke sumatic	To	Louis Fri 19a. Informant's Name/Relationship (7		_			City or Town, State, Zip C	ode)	
altimore, N	Pages 1 and intent of Health Int: If Item 27 ary or other tr		Richard Harris 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	20b. I Removal from State	Place of Disposition (N. cemetery, crematory or	other place)	Date	20c. Location - City or Town	n, State	
Baltin	permit. Pages Department of Important: If It eny injury or o		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	see	22. Name	emetery 03/2 and Address of Facility i Sagel Fune ockville Pik		Adelphi, MD		
100	Physician /Medical		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Nurt Bla blications that caused the dear one cause on each line.	th. Do not enter the mo			est, A	Approximate Interval Between Onset and Death	
8760,	Examiner Asicien and Parial-Hansit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect Due to (or as a consect Due to (or as a consect d.	phasia quence of):			jwe	eck	
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending phyrophetely filled in by the funeral director, page 2 should be detached for use as the prompletely filled in by the funeral director, page 2.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of of 9 □ Unknown	al death 3 □Ectopic			23d. Date of delivery Month D	/ Day Year	
rds, P.	quires that i n signed by uld be deta	d by Ph	Part II. Other significant conditions of	-	sulting in the underlying	4 44	23e. Did tol	bacco use contribute to the es 2 ☑No 3 ☐ Probal	cause of death?	
Records,	S S	Completed		O			24a. Was a autops perform	med? prior to com death?	sy findings available pletion of cause of	
Vita	ician: certifica rector, p	Be	25. Was case referred to medical examiner?	Hospital:		104	Death (Check only on			
Division of	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: Atter this certificate ha Completely filled in by the funeral director, page	ition; To	1 Yes 2 6 27. Manner Death 1 Autural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	T .	☐ Residence 6 ☐ Other (Specify) scribe how injury occurred		
Divisi	To the Hospital or Attending & within 24 hours after death. To the Funeral Director: After gompletely filled in by the funer	Certification;	3 Suicide 6 Could not by determined	28e. Place of Injury - At h building, etc. (Speci	eet and Number or Rural Route Number, , State)					
	he Hospitt n 24 hours he Funera bletely fille	Medical ((Check only 2 Medical Evan	ysician: To the best of my kn niner: On the basis of examin and manner stated.	ation and/or investigation	on in my opinion death or	courred at the time of	late and place, and due to	the cause(s)	
	withi To 1	2	29b. Signature and title of certifier 30. Name and address of person who MACY HAY 31. Date filed (Month, Day, Year) MAR 25 201	Haynes	Chap	9c. License number	971 1	NATUN 18	ROII	
	1		30. Name and address of person who MACYHAYY	completed cause of death (Ite	m 23a) (Type, Print)	lecularit	vive S	uiteza, no	120850	
Col Verezz	Sta Regist		31. Date filed (Month, Day, Year) MAR 25 201	37. Registrar's Sign	g fall	L.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ ira ACCVC 201 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and non Examiner 8 Date of Birth 9. Birthplace (State or Foreign If Unde If Under 24 Hrs. **Funeral** (Month, Day, Country) 1 □ M 2 🖫 F Mary **Director** 10d. Inside City Limits or items 23a or 28a-f shov 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County Director 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 2 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 ☐ Yes 2 ☐ No Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ickle Factor Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ဂ္ oleman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Moth Baltimore, 20c. Location - City or Town, State Disposition (Name of Date 20a. Method of Disposition 20b. Place of 1 M Burial 2 Cremation 3 Removal from State 30/11 hodesdale CAME 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Addre ero-Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. MD,21613 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 125 disease or condition resulting in death) Medical Due to (or as Examine ona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or The law requires that the death certificate be executed and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No After this certificate 1 🗌 Yes Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director. Division of Vital Hospital or Attending Physician: 25. Was case referred to medi-26. Place of Death (Check only one) To Be examiner? Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner 28d. Describe how injury occurred 28c. Injury at eath Certificate: work?
1 Yes 2 No injury Natural 5 Pending Investigation Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier the only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 30. Name and address of 300 Dorchester Avenue, Cambridge, MD Moore, M.D. Mary Ann

DHMH 17 Rev 7/2009

State

Registrar

MAR 30

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Monthpr 2, Physician/ 2011 10:18 AM Hemmis Nina Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland 111 West Second Street 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Country) MD Months Days Hours Min 1 □ M 2 □ ¥ Mec 4. 234-38-8233 Director 83 Usual Residence of Decedent 10d. Inside City Limits 10b. Count within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location Funeral Director Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 111 West Second Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **PPG Industries** billing dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Pearl L. (Allen) Cage Harry F. Cage 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 133 Pennsylvania Ave. Cumberland 19a. Informant's Name/Relationship (Type, Print)
Sue Buzzard MD 21502 daughte 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ื Burial 2 🗌 Cremation 3 🗀 Removal from State Sunset Memorial Park 4/4/2011 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature / Funeral Salice Licensee 22. Name and Carpelli Pulleral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ SQUAMOUS CELL Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and as the burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day 5 Other (specify) ed by the a 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 은 After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) ٥ 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:00p M March Valentina G. Jordan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Nursing Home Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 □ M 2 🗓 F Months Hours Manth 1 2 3 washington. 578-22-7749 87 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b, County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 Tes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20906 2901 S. Leisure World Blvd., 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " Montgomery County College (1-4 or 5+) Elementary/Seconday (0-12) Defemit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the Longe. Public Schools 12 Media Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Luisa Maggenti Paolino Girolami 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Print) 2901 S. Leisure World Blvd, #418, Silver Spring, MD Walter L. Finch - Son-in-Law Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 03/28/2011 | Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypertensive Heart Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Peripheral Arterial Disease Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying ng physician and as the burial-transit that the death certificate be executed Respiratory Insufficiency Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Deep Vein Thrombosis Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 Yes 2 No Year Month Dav Pregnant at time of death ed by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 X No 1 ☐ Yes 2 ☐ No Division of Vital Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗓 No ER/Outpatient 3 DOA 은 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending 1 X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier NUXOD March 24, 2011 D0047330 Women 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 W. Edmonston Drive, Suite 207, Rockville, Maryland 20852 Thomas V. Joseph, M.D.

State Registrar 31. Date filed (Month, Day, Year,

MAR 28 2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year James William 34 A M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Haberstown Washington Manor Health 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 🔀 M 2 🗆 F Hours West Virginia 67 **Director** 233-68-3103 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No S.C. Horry Myrtle Beach 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 29579 USA 506 Quincy Hall Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Force Black, White, etc. δ 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done dunna most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) law enforcement police force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Horace Hampton Hopkins Macie Blanch Kuhn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Quincy Hall Dr., Myrtle Beach, S.C. 29579 Sherry Kegley - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Beallsville, Maryland 4/2/2011 Monocacy Cemetery MINNICH FUNERAL HOME Truneral Service Licen 22. Name and Address of Facility E.Wilson Blvd., Hagerstown, Maryland 21740 415 23a. Earl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Dementio Medical Due to (or as a consequence of) Examiner terral sucustas wue to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Month Pregnant at time of death 5 Other (specify) Day to the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28c. Injury at work?
1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 💢 Natural 5 Pending 24 hours after death. Funeral Director; A 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the within Z 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) WH-5 1 Street Hoverstown MD State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ 515 AM ^M March 21 Allan Kernus Stuart Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) **Funeral** Days (Month, Day, 1 Year Country)
PA Months Hours Min. 1**X**□ M 2 □ F Yrs July Director 79 579-36-8383 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 🔀 Yes 2 🗆 No MD Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20852 Funeral 11430 Strand Drive #407 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Was Decedent Ever III o.s. Armed Forces?

1X Yes 2 No
If Yes, Give
Year or Dates. 1953-55 Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea any injury or other traumatic event, the Mea 4^{College (1-4 or 5+)} Elementary/Seconday (0-12) Certified Public Accountant Accounting Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Cecile Husky Max Kernus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 Mallinson Way Alexandria, VA 22308 Mitchell Kernus - son 20a. Method of Disposition
1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State King David Memorial Gardens 03/23/2011 Falls Church, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc.
1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licensee MQ1163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Intracraneal Hemorrhage (Not Traumatic) Priysician/ disease or condition Medical resulting in death) Examiner Cerebralvascular Accident Sequentially list conditions, Examine Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and I for use as the burial transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Xunknown Completed Coronary Artery Disease peen Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed Hyperlipidemia certificate 1 ☐ Yes 2 ☐ No 2 **X**N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 유 After this eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No M Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined

Division of Vital Records, 24 hours a To the 1. Vithin 2. To the F. Commoder

STUMRIT A.

State Registrar

Medical

29a. Certifier

(Check

only one

29b. Signature and

31. Date filed (Month, Day, Year) MAR 25 2011

ame and address of person who completed cause of death (Item 23a) (Type, Print)
David Guevara-Nieto MD 8600 Old Georgetown Road Bethesda MD 20814

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number D68405

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

March 21, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Day Month Abdul W. Karim 2011 17 3 12:12 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Rockville Montgomery **Funeral** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 3/26/1929 Year) 1 X M 2 - F Months Days Hours Min Director 228-17-5281 Afghanistan Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No VA Fairfax Fairfax 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4417 Saint Edwards Pl 22030-4429 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: White Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ambassador Forgeign Affairs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abdul Khaliq Olomi Shawbobo Etimadi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13553 Wembley Loop, Bristow, VA 20136-5752 Abdul Karim - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) National Memorial Park 3/12/2011 Falls Church, VA Signature of Fureral Service License 22. Name and Address of Facility National Funeral Home 7482 Lee Hwy. Falls Church. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death cardio ulmonar Physician/ disease or condition Medical resulting in death) Due to (or as a con equence of): Examiner astri metastatic · (_ Securitally liet or clitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury e attending physician and Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy death? 2 N Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: ၉ 24 hours after death.
Funeral Director: After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Cortifying Nurse Practioner: To the best of my knowledge, death of 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 69148 in u 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

MARICHU MATAS, MD

31. Date filed (Month, Day, Year) MAR 2 5 2011

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10110 MOLECULAR DRIVE, SUITEZ, ROCKVILLE, MARYLAND 2050

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 -** For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 2011 Physician/ Ĭő, 10:08 PM Virginia Rae Kam<u>mann</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, Yea April 15, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Funeral Country) Minnesota 1 🗆 M 2 🛭 87 April Director 559-38-8382 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland al Hygiene. or items 23a or 28a-f sho 10a. State Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12428 Dewey Road Funeral 20906 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 X No δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Caucasian "natural", Completed 3 X Widowed 4 Divorced traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic Elementary/Seconday (0-12) College (1-4 or 5+) Systems Analyst Computer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Shadwick Ilder unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12428 Dewey Road, Silver Spring, Maryland 20906 Sandra Kammann, daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place, 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Fort Lincoln Crematory March 29,2011 Brentwood, 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 Signature of Funeral Service Licenses MO1102 Kowe 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final instant Physician/ Acute Coronary Syndrome disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate and Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the buna Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 9 Unknown To the Funeral Director, After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 □ No 3 □ Probably 4 🕅 Unknown Alzheimer's Dementia 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hypertension autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🎦 No 1 Inpatient 2 X ER/Outpatient 3 I DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 X Natural iniury 5 Pending after death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 29b. Signature apportitle of certifier 29d. Date signed (Month, Day, Year) 29c. License number D28656 March 19, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15245 Shady Grove Road #130, Rockville, Maryland Ravi Passi MD

State

Registrar

31. Date filed (Month, Day, Year)

MAR 25 2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 731 15:15 Medical a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Davs Hours Min. 429-64-4966 Director 73 Yrs Feb. 19. 1938 Arkansas Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland | Prince Georges 1 Yes 2 X No Upper Marlboro 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 3613 Halloway North 20772 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner any injury or other traumatic event, the Medical Examiner. Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🕱 No If Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Realtor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Watt Bryant Virgie Kea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Keegan/ Husband 3613 Halloway North, Upper Marlboro, Maryland 20772 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State 3-29-2011 Davidsonville, Maryland Lakemont Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home alha Solomons Island Rd., Edgewater, MD 21037 23a. Cart.—Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, CANCEL disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or impury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal dea in the past 12 months? Month Dav Year signed by the at Id be detached for 1 ☐ Yes 2/C 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ျ 1 Tyes 1 Inpatient 2 FR/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w 2W3

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Catherine V. Kearney 0^{Month} 22 2 201 Tea 7:03 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Fort Washington Hospital Fort Washington If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7 Age (In vrs last hirthday) Funeral Days Hours Min Country) NC 1 M 2 F 11/11/1920 240-76-1695 Director 90 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Oxon Hill Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5134 Deal Drive, Apt.#302 United States 20745 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' Black, White, etc. ori 1 Never Married 2 Married Completed by ☐ Yes 2 🛣 No 72 hours after Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: If Yes, Give 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Maid Private should be filed with and Mental Hygien ris marked other th 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Connie Mcknight Lettie Floyd traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 i Tennille Davis/Grand-daughter 1774 Mississippi Ave, Wash., DC, SE 20020 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If it any injury or of ₽ 1 🖺 Burial 2 🗌 Cremation 3 🗎 Bemoval from State Resurrection Cemetery 03/30/2011 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope Funeral Home, P.A. 21. Signature of Funeral Service Licen 5538 Marlboro Pike, Forestville, MD 20747 ans MOI 083 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Acute Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Lobar Pneumonia Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed Dementia Were autopsy findings available prior to completion of cause of 24a, Was an Sick Sinus Syndrome has page 2 death? perform certificate 1 Yes 2 No 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 🔽 No ပ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 1)42755

State Registrar 12017 Fort Washington Road, Fort Washington, Maryland 20744

use of death (Item 23a) (Type, Print)

32. Registragi Signa

who completed c

30. Name and address of person

31. Date filed (Month, Day, Year) NAR 2 9 2011

Edar V. Potter, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 26 2011 Month Arthur Lovell Samuel March 10:00 AM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery 7710 Maple Avenue #602 Takoma Park Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Hours Months 1**™**M 2□ F 62 579-96-4339 12-20-48 Barbados WI Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 □ No Takoma Park MD. Montgomery 10f. Zip Code 10g. Citizen of What Country's 10e. Street and Number Barbados 7710 Maple Avenue #602 20912 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Real Estate Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **Ula Chase** Samuel A. Lovell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20011 Gail Lovell/Wife 4840- 7th Street, N.W. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Christ Church Burial 2 Cremation 3 Removal from State 4/16/11 Coral Ridge Cem. 4 ☐ Donation 5 ☐ Other (Specify) Barbados, WI of Funeral Service Licens 21. Signat 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. 814- Upshur Street, N.W Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Consequence of Due to (r as a consequenterf): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 11.00 Due t for as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

Certification: To Be

Medical

29a. Certifier

Physician

/Medical

10a. State

Director

Funeral

þ

Completed

Be

Examiner

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experient is ust be rediffied at once.

physician and s the burial-transit attending ph ned by the a signed to peen has e 2 s page this certificate Hospital or Attending Physician: After th funeral

The law requires that the death certificate be executed

Box 68760

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Division of Vital Records,

To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Algorithms of the funeral Director of Completely filled in by the funeral parts of the funeral death.

Part II. Other significant conditions	contributing to death but not rest	uiting in the underlying	cause given in Part I.	23e. Did tobacco use			
Hyperlipides	ula, Severe	Hyperte	rusta.	1 ☐ Yes 2 ☐ N			
Anemia,	Morbid O	besite		24a. Was an autopsy performed? 1 □Yes 2 ▼No			
25. Was case referred to medical examiner? ★ Yes 2 □ No	26. Place of Death (Check only one)						
	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Other: 4 Nursing H	Home 5 X Residence 6 □			
27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at	28d. Describe how injury or			

1 Natural 2 ☐ Accident 5 Pendina

investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 Thomicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other (Specify) ccurred

28f. Location (Street and Number or Ruràl Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number D53098

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elise C. Riley, 7987- Ga. Ave. Silver Spring, Md. M.D.

State Registrar 31. Date filed (Month, Day, Year) MAR 28

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 23, Day 2011 William Dallas Lewis, III 4:51a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Casey House Montgomery Rockville . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 x M 2 □ F April Day 9 ,1929 Columbus, OH 300-18-4371 81 Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location Director must be notified MD 1 X Yes 2 No Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 10124 Gravier Court 20886 United States death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>م</u> 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 2 No altimore, Maryland 21215-0036 Specify: African 1 ☐ Yes 2 ₩ No Specify: Completed 3X Widowed 4 Divorced Year or Dates 946-47 American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Small Business Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Dallas Lewis, II Cornetta Lyman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Lewis Lewis/Daughter Glencoe Ave., #310 Marina Del Rey, CA 90292 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 03/25/2011 Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee 6. 7400 Georgia Avenue, N.W. Wash., D.C. 20012 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Prostate Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for es a nonsecuenne of cause. Enter Underlying Cause (Disease or iinjury Exami attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Multiple Myeloma 2 KNo 3 ☐ Probably 4 ☐ Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k completed filled in by the funeral director, page 2 s autopsy performed?
Yes 2 1 No 2 No 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 X No 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 9 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury X Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 29b. Signatore and title of certifier

31. Date filed (Month, Day, Year

Debrah Miller CRNP;

MAR 28 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

DHMH 17 Rev 7/2009

6001 Muncaster Mill Road; Rockville, MD

29c. License number

R143201

29d. Date signed (Month, Day, Year) 3

20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gail Elizabeth Lumpkin March 2011 12:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 117 Harmony Hall Road Gaithersburg Montgomery 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign If Under 24 Hrs **Funeral** 1 - M 2 X F Months Hours April 25 1943 Washington, D.C. Yrs. Director 217-42-3450 67 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the first part of Health and Mental Hygiene. and the first part is marked of the than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 117 Harmony Hall Road 20877 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes timore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 X Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Public Service Aide Police Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Samuel Claggett Long Irene Creech 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tami L. Lumpkin/Daughter 1532 Danewood Court, Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If it any injury or of once. 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 03/26/2011 Rockville, MD Parklawn Mem. Park 22. Name and Address of Facility Signature of Funeral Service Licensee DeVol Funeral Home Mª Millian Kiran MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Malignant Neoplasm of the Duodenum Months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed as the burial-transil by the attending physician and stached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\bar{K} \) No Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month. Dav. Year) 1C 6 D37142 March 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Coleman, MD, 1355 Piccard Drive, Suite 100, Rockville, MD 20850 31. Date filed (Month, Day, Year) State MAR 25 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SAUNDRA ADRIAN LEE 1403M 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Columbia Howard Howard County General Hospital 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
10-26-72 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2XX 38 579-80-3547 Director Wash. DC Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD. Howard Columbia 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5655 Columbia Road, #202 21044 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or iter the Medical Examiner Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Program Coordinator WMATA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daryl Davis Louise Timbers and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daryl Davis/Father 9223 Willow Lane, Hyattsville, Md 20783 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Heritage Mem. Cem 3/29/11 Waldorf, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility Hackett's Funeral Chapel, 814- Upshur Street, N.W. 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

LACTIVIAL ARGURTEON Approximate Interval Retween LACENTAL Immediate Cause (Final Onset and Death ABRUBTION Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No for 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔭 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 💆 Natural injury 5 Pending Accident
Suicide Investigation усопріете filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Solah DØØ70109 7-211

State Registrar

31. Date filed (Month, Day, Year) MAR 25 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Esteban Schabelman, M.D. 5755 Cedar Lane, Columbia, Md. 21044 32 Registrar's Signatu

Box 68760

P.O.

Records,

of Vital

Division

DHMH 17 Rev 1/2001

the attending physician led for use as the burial Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 signed by this certificate has been Division of Vital After within 24 hours after death.

To the Funeral Director: filled in by the

2

Completed

Be

examiner?

1 Natural

2 ___

3

1 🗸 Yes

Manner of Death

Accident

Suicide

29b. Signature and title of certifier

Pamela E. Southall, MD

4 V Homicide 29a. Certifier 1

Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' ✔ Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 Inpatient Other₄ 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 2 No 8a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Mar 21, 2011 Subject was assaulted 2345 hrs Pending 1 Yes 2 V No Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) 6417 Main Street, Queenstown, MD determined (Specify) Single Family Home

31. Date filed (Month, Day, Year) State Registrar

Registrar's Signature

Assistant Medical Examiner

and manner stated.

30. Name and address of person who completed cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

To the

29d. Date signed (Month, Day, Year)

March 22, 2011

Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ : 40 PM MARCH John Pau1 Landis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 6. Sex 7. Age (In vrs. last birthday) Days Hours 06/28/1919 1 X M 2 - F 137-12-8451 91 Director Pennsylvania Usual Residence of Decedent show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location must be notified at Director 1 Yes 2XX No Mitchellville Maryland Prince George's 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 10450 Lottsford Road #3008 20721 S. Α. 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No If Yes, Give Year or Dates. 1941–52 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Superintendent Norfolk Southern Elementary/Seconday (0-12) College (1-4 or 5+) Stations and Transfers Railroad Corporation Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Μ. Landis Magdalena Shaddinger injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sam Bogley/Attorney 13306 Gallery Court, Bowie, Maryland permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Arlington National 1 X Burial 2 Cremation 3 Removal from State 7/11/2011 Arlington, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home, 21. Signature of Funeral Service Licensee Sen 1. Kind 16000 Annapolis Road, Bowie, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of): Examiner Peritonitis Sequentially list conditions, if any, leading to immediate oauce. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 L 9 Unknown Yes 2 No been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed? Yes 2 No 2 🗆 No this certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After X Natural 5 Pending in 24 hours after deau...
the Funeral Director: Aff 2 Accident
3 Suicide
4 Homícide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier MDD58182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Cecil

D.

31. Date filed (Month, Day, Year)

George.

5 2011

M.D.

7500 Hanover Parkway, Suite 101A, Greenbelt, MD 20770

Please Type or Print in Black Indelible Ipkt Ensure All Copies Are Legible.

Item I approved by Mied Library Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O Physician/ Vear 08:38 P M Albert Ray Lewis 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of-Maryland Medica 1timore Baltimore LeuTei Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday **Funeral** Month, Day, Year) ine 30,1934 Days Months Hours 1 X M 2 🗆 F 236-50-0467 76 Luke, MD Director Tune Usual Residence of Decedent 28a-f show with the Maryland 10a, State 10b. County 10c. City. Town or Location notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Allegany Westernport MD 10e. Street and Number ö 10f. Zip Code 10a. Citizen of What Country? "natural", or items 23a or edical Examiner must be r Funeral 21410 New George's Creek Road, S.W. 21562 USA should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 1 Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced Specify: Completed White 1952 the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) (GED) Accutrim Operator Paper Mill 12 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Goldie McCauley William G. Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 21410 New George's Creek, Rd., SW Westernport, MD Mary K. Lewis/ Wife Baltimore, 20c. Location - City or Town, State 21562 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) March 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 2011 Keyser, WV 21. Signature of Funeral Service License 22. Name and Address of Facility Smith Funeral Home Main Street Keyser, WV 85 S. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death spine Physician/ injury disease or condition resulting in death) Medical Due to (or as a construence of): Examiner aovti Sequentially list conditions. CERTIFICATION APPROVED BY MEDICAL Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? õ Month Day Year Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown g | Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe (2 No 3 □ Probably 4 □ Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform this certificate the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred SUNTECK 1957 COT VENIUE Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending 16/2011 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, roadway Maryland Hw Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD Ye, 209 03,191 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Street Raltimore. INGXIANG Greene

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 201 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Manth 231 Richard Lee Montgomery, Sr. 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Hagerstown Meritus Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year, 5/11/1942) Country)
Maryland Director 220-40-2328 68 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 372 Nottingham Road 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Manufacturing Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ೨ Lillian DeFlage Virgil Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy A. Montgomery / Spouse 372 Nottingham Road, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Haven Cemetery 3/30/2011 Hagerstown, Maryland 21. Signature of Funeral Service Licersee 22. Name and Address of Facility Rest Haven Funeral Chapel 5 Men 1601 Pennsylvania Ave., Hagerstown, 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one complications are complicated as the complete state. Approximate Interval Between Oriset and Death s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ℓ Immediate Cause (Final Physician/ FILE disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ue to (or as a consequence of) and I-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death signed by the a 9 Unknown 9 Unknown ntributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ ₩0 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 724a. Was an autopsy performed? Yes 2 has 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 🗹 No ဂ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) ertifying Nurse Rractioner: T🗸 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature ar

State
Registrar

211-5+1

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

11110 Medical Campis Rd.

21742

completed cause of death (Item 23a) (Type, Print)

DOSTER

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NAR 2 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ March 17, Linda Ann Mc Donald 1305 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince Georges Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Oct 15, **Funeral** 1 🗆 M 2 🖾 F Months Days Hours Yrs 1920 North Carolina Director 578-48-5298 90 Usual Residence of Decedent ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director Landover Maryland Prince Georges Yes 2 No 10f. Zip Code 20785 10g. Citizen of What Country? 10e. Street and Number 3309 Dodge Park Road Funeral Apt. T2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: "natural" 3 ♥ Widowed 4 □ Divorced Year or Dates artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natui injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Domestic 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Johnnie Richardson Molly B. Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Niece) Patty Henry 3309 Dodge Park Rd. #T2 Landover, Md. 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) Cedar Hill Cemetery 03-25-2011 Suitland, Maryland 22. Name and Address of Facility
W. H. Bacon Funeral Home, Inc.
3447 14th Street, N. W. Washington, Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) 1 Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): eral Director: After this certificate has been signed by the attending physician: filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🖾 No Day 5 ☐ Other (specify) Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? To the Hospital or Attending Physician: The 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita 1 Yes 2 Z No Other: ပ္ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print)

Registrar

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State

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VERMA

5

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month 3 20111 **Physician** 7:10 A Rosie E /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Citizens Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 1/1/1923 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**X** F 88 Director 219-20-4814 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Knoxville MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21758 221 Knoxville Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: Specify: White 2 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", any Injury or other traumatic event, the Modical Exposes. Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) J. J. Newberry Sales Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Virginia Stewart Clarence Edward Moss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Moss, Niece 1306 Rosemont Drive, Knoxville MD. 21758 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Reformed Cemetery 3/26/2011 Knoxville MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Vallan John T Williams Funeral Home, Brunswick MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause qn each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (o) as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed n Sin Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rector, page 2 performe 2 No 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No director, Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifler completely (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D0055061 Mid 300 WEST NIND+, Frederick 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 32. Registrar's Signature State Registrar Darke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>011</u> Month **Physician** Thomas Martin Maxwell March 19, 9:50 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Kline Hospice House Mount Airy 8. Date of Birth (Month, Day, Year) Aug. 13, 1963 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Months 1 ☑ M 2 ☐ F 47 Washington, DC Director 218-86-2002 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if Medical Evantinal must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo Frederick Frederick Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1735 Carriage Way 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ₩No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Superintendent Building Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Clayton Maxwell, Jr. Delores Devile ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Maxwell / Brother 1409 Kempner Park, Robinson, TX 76706 20b. Place of Disposition (Name of cemetery, crematory or other place)
Restnaven
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State March 24, 1 X Burial 2 ☐ Cremation 3 Removal from State 2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other Specify) 21. Signature J Funeral S vice Licens Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseas shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Immediate Caus (Fina **Physician** 6 months disease or condition resulting in death) a Brain Tumor - Astrocytoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) cate has been signed by the page 2 should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2K No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 2 🖾 No 1 🗆 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) House 1 ☐ Yes 2 🔼 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural n 24 hours after death.

le Funeral Director; Aft
bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D 0036610 March 23, 2011

Registrar

State

56 Thomas Johnson Dr., Ste. 200, Frederick, MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Fisher, M.D.

Edward F. Fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month P M March 26, 2011 4:00 Ronald Woodrow Mohr /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Mallard Bay Care Center Dorchester Cambridge If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 1 X M 2 □ F March 12,1947 64 Director 212-48-3428 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Directo Federalsburg Maryland | Caroline 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21632 USA 5509 Maple Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than aumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Service Department Manager Heating Fuel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Emma Hildabrandt Woodrow Louis Mohr ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unit of Health and the If item 27 is a vor other Deborah F. Mohr/Wife 5509 Maple Drive, Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Bethel UMC Cemetery 3/31/2011 Federalsburg, MD 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207
106 Main Street, East New Market, 21. Sign ture of Funeral Service Livens 21631 Approximate Interval Between Onset and Death 22a. Part I. Enter the disease shock, or heart failure. I e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one-cause on each line. Immediate Cause (Final Physician athlero sclerotic Vascular disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner tailure orgar Sequentially list conditions, Examiner n any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be execute obstruction physician and the burial-trans resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death

Pregnant at time of death 3 Ectopic pregnancy Day 5 Other (specify) signed by the a ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1XYes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending investigation after death. Director: Af 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3/28/

State Registrar 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

100 L Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4:15 March 2011 Milhollan 27 David рм 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Talbot 713 Elizabeth Street Easton Social Security Number 1 Year Days Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Min. Hours Month, Day, Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, College (1-4 or 5+) Elementary/Seconday (0-12) Eather's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Rel nship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee 22. Name and Address of Facility Will Shore Crematro 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death V disease or condition 4000 resulting in death) Due to (or as a consequence of). Sequentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No 2 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

Other

1 Yes

2 No

28c. Injury at

5X Residence 6 Other (Specify,

28f. Location (Street and Number or Rural Route Number,

MI

21201

28d. Describe how injury occurred

Physician/ Medical Examiner Examiner

Physician/

Examiner

Funeral

Director

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death with the Maryland

"natural", or items 23a or 28a-f sho edical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygener. atturally, or important: If item 27 is marked other than "naturally, or any injury or other traumatic event, the Medical Exami

Baltimore, Maryland 21215-0036

Medical

Director

Funeral

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Completed

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10a. State

attending physician and for use as the burial-transit Be ပ Certificate:

Physician/Medical ş Completed

IF FEMALE:

1 Yes

Manner of Death

Natural

Accident

Suicide

4 Homicide

5 Pending

Investigation 6 Could not be

determined

the Hospital or Attending Physician: The law requires that the death certificate be signed by the this certificate has ral director, page 2: After this funeral of

Division of Vital Records, P.O. Box 68760 within 24 hours after death

To the Funeral Director: / Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5247 and address of person who completed cause of death (Item 23a) (Type, Print) Baltimar 22 onth, Day, Ye 31. Date filed (Month, Registrar's Signaty State Registrar

28a. Date of injury (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

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Baltimore, permit. Page 1 and Department of Hee mportant: If item any injury or othe		20a. Method of Disposition 1 D Burial 2 Cremation 3	Removal from State C	Place of Disposition (Name of cemetery, crematory or other pla	ce)		Location - City of	. 440
Baltimo permit. Page Department o Important: If any injury or	ail l	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License		terans Ceme	tery 3/2/		urlock	, 100.
Baltil permit. F Departm Importal any injur	ouce	Danelle C	Henry	5/0 W/0	ess of Facility 114 uneval 14 UShington	V ST. Ca	Mbrida	c.MD.21613
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Records, P.O. Box 68760 The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the burial	Completed by Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death $3 \square$ Ectopic pregnar death $5 \square$ Other (specify)	icy		Month	Day Year
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Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director. After this certificate has been signompleted filled in by the funeral director, page 2 should b	Certificate:	3 Suicide 6 Could not be 4 Homicide determined		ome, farm, street, factory, office	2	8f. Location (Street City or Town, St		ural Route Number,
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<u> </u>		30. Name and address of person who camesh Schopal		n 23a) (Type, Print)	Road Is	alhmor	· Man	th, Day, Year) 21 2011 y land 21221
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	· wa /	277.00		1
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#18 per FH State of Maryland / Department of Health and Mental Hygiene State Registrar 3/25/2011 AACO HEALITH DEPT. CMH Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 0920 M Phin 0. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Severna Park 4c. County of Death
Anne Arundel Examiner Kris-Leigh Assisted Living cial Security Numbe 7. Age (In yrs. last birthday) 103 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) Oct. 5, 1907 Days 217-14-9749 1 🗆 M 2 🗙 F Min. **Director** Maryland Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Delaware Sussex Seaford 1 Yes 2 X No 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 30 Marathon Drive 19973 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72.1th and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Accountant General/Assistant U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Theresa (unknown) Salvatore Franco, Sr. Pracotto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 348 Fairtree Plaza Extended Severna Park, MD 21146 permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trans Thomas A. Mayo, Jr./son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XXBurial 2 Cremation 3 Removal from State New Cathedral Cemetery 3/28/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 0 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart fallure. List only one cause on each line y Dia Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) em Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events resulting in death) Last anding physician and use as the burial-trar Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Year Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, the Hospital or Attending Physician; The law requires 1 Tes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes Yes 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) the funeral director LEIGH 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Division after death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Light State of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi 29c. License number Name and address of perso o completed cause of death (Item 23a) (Type, Print) M HAR VM 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month March 2011 Edwin Willard Moffitt 3:45p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1923 Champlain Drive Severn Anne Arundel Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Days Months Min. Hours 4-14-1914 Director 567-26-9781 Deltaville, 96 Usual Residence of Decedent show 10a. State 10b. County with the Maryland Director 10c. City, Town or Location notified at 10d. Inside City Limits 28a-f MD Anne Arundel 1 X Yes 2 □ No Severn 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 1923 Champlain Drive 21144 <u>United States</u> permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces?

1 💆 Yes 2 🗆 No 17 Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed 3 🗌 Widowed 4 🗌 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service 4 Employee development officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edwin James Moffitt Elliott Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne L. Moffitt/Wife 1923 Champlain Drive Severn MD 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 3-30-2011 | Brentwood, MD 21. Signature of Juneral Service 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner SRTSN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year signed by the at d be detached for Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENATA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Yes Other: ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 A Residence 6 Other (Specify, After thi funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending n 24 hours after death. e Funeral Director: Af pleted filled in by the fu 1 Tes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 only one) Certifying Nurse Practioner: To the best of knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and₄title of 30. Name and address of person who completed eause of death (Item 23a) (Type, Print) 5E RITCHIE HIGHWAY KIC HARD ISHE 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 1920 Mitchell 03 L. Andrew Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Center Clinton if Unde If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1 M 2 □ F Days New York Months Hours Min 07/16/1932 Director 238-42-6405 28a-f shov 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland **Funeral Director** notified 1 X Yes 2 □ No Prince Georges Clinton MD 10f Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ō must be 23a 8711 Jeremy Court 20735 ural", or items? 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
Yes 2 No 1953-Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 1955 "natural" 3 Widowed 4 Divorced Completed Black the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Chief Engineer of Health and Mental Hygistem 27 is marked othe other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၉ Andrew T. Mitchell Amanda Branch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau MD <u>Earlene P. Mitchell/Wife</u> 8711 Jeremy Court Clinton, 20735 altimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Veterans Cemetery 04/01/2011 Cheltenham, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Signature of Funeral Service Licensee Soupa Montgomen 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be read hours after death.

Eat hours after death.

The Internat Director: After this certificate has been signed by the attending physicis reted filled in by the funeral director, page 2 should be detached for use as the burneted. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Hospital: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural injury 5 Pending work?
1 Yes Investigation Accident 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 0 31. Date filed (Month, Day, 32. Registras Sign

State

'Registrar

MAR 2 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ \mathbf{P}^{M} 2011 March 19:04 Norris Clara Catherine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 17323 Diane Dr. Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country) Days Min. (Month, Day, Year) 8/16/1932 1 □ M 2 X F Director 220-26-5519 78 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Hagerstown MD Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17323 Diane Drive 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ğ 1 Never Married 2 Married 2 II No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced White traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Janitoria1 Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ျ Gertrude Viola Timmons Henry Clinton Barnhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19646 Marigold Drive, Hagerstown, MD 21742 Dixie Gaver / Daughter 27 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/31/2011 Haven Cemetery Hagerstown, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave., Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed that initiated events Due to (or as a consequence of): ш resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page performed? 2 0 No certificate 1 Yes 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 2 C No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After ■ Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of ce 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ennsilvaniadie State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $2011^{\rm Year}$ Physician March 28^{Day} Frederick Joseph Naimo 12:35 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Willaimsport Williamsport Washington County 6. Sex 1 M 2 ☐ F 8. Date of Birth March 17,1918 9. Birthplace (State or Foreign New York 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 93 Days Hours 059-12-3659 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Eventings must be notified at Maryland Washington County Williamsport 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 16505 Virginia Ave. 21795 U.S.A. Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 1941 - 1745, Give 1941 - Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify. Specify: White 3 XWidowed 4 □ Divorced 945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tool & Dye Maker Truck Mfg. 12 1.2 should be filed w. h and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antonia DiMartinis Marion Dimargio DiMartinis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s. Department of Health ar Important: if item 27 Is any Injury or other trau Anita N. Hennesy-daughter 910 Potomac Ave. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 3-30-2011 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caus, of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ogset and Death Immediate Cause (Final Union A **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): lor Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐Yes 2 ☐ No 5 Other (specify) detached 9 Unknown ģ signed to be detail Other significant conditions contributing to death but not resulting in the underlying cause given 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 1 ☐ Yes 2 ☐ No 25. Was ease referred to medical examiner? filled in by the funeral director. Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 2. 29b. Signatu 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Pri JH3+1 460 31. Date filed (Month. State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ 03/0 M REMSKI EONARD 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Ye May 22.1 Social Security Number . Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 🗆 F Hours 169-28-0080 73 Director 1937 May Pennsylvania Usual Residence of Decedent or 28a-f shov within 72 hours after death with the Maryland Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Millersville 1 🗆 Yes 2 💢 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 793 Springbloom Drive 21108 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No If Yes, Give Black, White, etc. "natural", or þ 1 Never Married 2 Married 1960-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Divorced 4 Divorced 1961 Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Steelworker of Health and Mental Hygien filem 27 is marked other th 12 Steel Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Leonard Obremski Francis Adamiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Pohlmeyer / Daughter 793 Springbloom Drive Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) March 25, ō injury Metro Crematory, INC 2011 Baltimore, MD 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service License art 1. Inter the disease, or hock, or heart failure. List of rications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ne cause on each line. 23a art 1. Interval Between mediat Cause (Final disease condition on Physician/ resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examiner but to for sea none squence of, E Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this continued to the as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 prior to completion of cause of death? 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No 은 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1_ Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of certifie har aus led cause of death (Item 23a) (Type, Print) Name and address of persor 441 31. Date filed (Mo 32 Registrar's Signature State 5 2011 2 Registrar

11-02496

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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)			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Civista Medical Center□□ La Plata						4c. County of Deat		
	uneral rector		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/N Months Days Hours Min. May 13, 19					irth(MM/DD/YYYY) 9. Bi			
	any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locat	ion				10d. Inside City Limits
land	28a-f show I at once.	tor	MD Charl	es	W	aldorf	Lot 7: 0 L			40- 00 - 100	1 Yes 2 No
the Man	a or 28a tified at	Director	10e. Street and Number 5509 Torpedo	Court			10f. Zip Code 2060	3		10g. Citizen of What Cou El Salvad	•
0036 within 72 hours after death with the Maryland	al", or items 23a or 28a-f sho ner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 M 3 Widowed 4 Div	larried		If Y		n, Mexican, Pue El Sa	(Specify Yes or Nerto Rican, etc.)		rican Indian, Black, White
036 ithin 72 hours	Hygiene. Inther than "natural", the Medical Examiner		15. Decedent's Education (Spe Elementary/Secondary (0-12) 6th			during m	t's Usual Occupa ost of working life ructiol	DO NOT use	retired)	16b. Kind of Business	'Industry
21215-0036	S 2 3	Be Co	17. Father's Name (First, Middle Jose Maria I	,						Maiden Surname)	i a
	and Mental F 7 is marked natic event, 1	의	19a. Informant's Name/Relations	hip (Type, Print)	D + 1-					Santamar	
e, MD	Department of Health and Important: If item 27 is injury ar other traumat		Jose Vilnova 20a. Method of Disposition		20b.	Place of Dispos	ition (Name of ce	metery,	Date	20c. Location - City or	
Baltimore, eemit. Pages 1 a	tant: If		1 Burial 2 Cremation 4 Donation 5 Other S	pecify:	State Car	Como	terv	4	/7/11	1	El Salvado:
Bal	Depar Impo injury		21. Signature of Funeral Service		595	99	o 8 Sass	afras:	ridgen Ln.Mito	Funeral Schellville	ervice ,MD.20721
/M	sician edical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.			_	, such as cardia	c or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death
≟xa	miner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co			1Cation				
		miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	nsequence o	of):					
ited	d ansit	Ä	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence o	rf):					
O, be executed	/sician and burial - transit	edical	□ AMENDED 23a,pt.II,27,28a-f per me g914 4-22-11 vt						11 vt		
Records, P.O. Box 6876(u: The law requires that the death certificate	the attending physed for use as the b	ΣI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown								
P.O. F	signed by the	by Ph	Part II. Other significant condit	_	eath but not r	esulting in the u	nderlying cause	given in Part I.		obacco use contribute to	
of Vital Records, F	e has been sign re 2 should be	Completed	Chronic Alcoholism 1								
al Re	his certificate director, page	Be Co	25. Was case referred to medica examiner?				26.Place	of Death (Che		2 No 1 Y	es 2 No
of Vit	After this c	ျ	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpa		ER/Outpatient 28b. Time of Ir		Other Nur	sing Home 5	Residence 6 Other	r
ion C	the the	ation	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation fd 3-31-11 fd 10:26pm 1 Yes 2 No unknown								
28e. Place of Injury - At home, farm, street, factory, office building, etc.						State) 5509 Tor	reet and Number or Rural Route Number, City ate) 5509 Torpedo Ct. Charles Co., Md.				
Tn the Hosp	로 등 등 📆 📆 (Sheek with 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as sta										
	To To	Medi	29b. Signature and title of certifie	and manner state	ed		29c. Licens	e number		29d. Date signed (Mo. April 1, 2011	
RB	$_{I}$		30. Name and address of person	who completed cause on the Medical Examination	,	_	t, Baltimore,	MD 21201			
. 00		ate	31. Date filed (Month, Day, Year)	37 Regis							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G914 4/18/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month March 2011 8:02 P Ki Young Park Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number 213-33-1544 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Year) 19<u>30</u> Davs (Month, Day, Months Hours Min. Director Oct. 80 Korea Usual Residence of Decedent 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Georges College Park 1 Yes 2 No 급 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 9014 Rhode Island Avenue #600 20740 United States items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Examiner Armed Forces?
1 ☐ Yes 2 🗓 No o. ģ 1 Never Married 2 X Married within 72 hours after Specify: Korean 1 Yes 2 No Specify: If Yes Give "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Bartender Rar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Yi Kun Park Kea Nam Choi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 9014 Rhode Island Avenue #600, College Park, MD 20740 Tae Soon Park, spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State injury c 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 3/25/2011 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signat re of Funeral Service Licensee MO1102 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph sician Myocardial Infarction Medical Due to (or as a consequence of) Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. E. ter on Jenying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Hypertension and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Congestive Heart Failure IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No Yes ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 X No this certificate 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: မ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) Medical

Division of Vital Records, P.O. Box 68760 ne Funeral Director: After the pleted filled in by the funeral within 24 hours a

To the Funeral Completed filled

Baltimore, Maryland 21215-0036

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

29c. License number

1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year,

D67355

March 21, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Sherk, 1500 Forest Glen Road, Silver Spring, Maryland 20910

State Registrar 29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1425 March 24,2019 Rizkallah E. Madlin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Monigomery Examiner Silver Holy Cross Hospital 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🏝 F Days Months Hours Min 4 199333 212-78-3038 77 Palestine Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Silver Spring Montgomery 1 Yes 2 No 10f. Zip Code 20902 10e. Street and Number 10g. Citizen of What Country? Funeral 2419 Dexter Avenue 72 hours after death 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White and Mental Hygiene. 3 Widowed 4 Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) honemaker Own Home College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Saran Ghanem Elias Mansour 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2415 Dexter Avenue Silver Spring, Md 20902 permit. Page 1 and 2 st Department of Health a Important: If item 27 is Elias Rizkallah/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Silver Spring, Md 3/28/2011 1 Burial 2 Cremation 3 Removal from State Gate of Heaven injury 4 Donation 5 Other (Specify) PANETIE INPANDESS RINNALDI FUNERAL SERVICE, P.A. uneral Service LC any 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Aspiration pneumonia Sequentially list conditions if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death ed by the a detached f 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed to completed filled in by the funeral director, page 2 should be det. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary artery disease 1 🗌 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Renal failure 24a. Was an Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မူ 1 Main Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature ar 29d. Date signed (Month, Day, Year) 3/24/2011 D40365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd Silver Spring, Md 20910

Registrar

State

Peter J.Sabia
31. Date filed (Month, Day, Year)

MAR 28

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Annette Reinhardt March 24, 2014 6:00ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Hebrew Home of Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 6. Sex **Funeral** Age (In yrs. last birthday) 90 Days Min. 2/01/1921 056-16-3793 1 🗆 M 2 🔀 F Director New York Usual Residence of Decedent 28a-f show Default. Page 1 and 2 should be filed within 72 hours after death with the Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Mash Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md Montgomery Rockville Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Montrose Road 20852 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Bookkeeper Elementary/Seconday (0-12) College (1-4 or 5+) Import Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Sam Solomon Fay Solomon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sam Whitehorn/son-in-law 5812 32nd Street N.W.Washington, D.C. 20015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date New Montifiore Cem 3/27/2011 West Babylon, NY 1 XBurial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 21. Signature PHTETPACTS KINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Advanced Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year by the a 9 Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page Yes 2 XN 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital Be 1 ☐ Yes 2 💢 No Hospital: Other: ᅆ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c, Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number mina 3-24-2011 D0064871 Fare 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville Montros e tazli MD 6121 MD Mina 32 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 11:50pm June I. Rasmussen March 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Bedford Court Assisted Living Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** Year Months Days Hours 1 □ M 2 🕱 F Yrs 09/28/1919 396-03-8734 Wisconsin Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 👿 No Director Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. natural", or items 23a 3376 Chiswick Court, #522 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married þ 1 ☐Yes 2X No Specify: Specify: Caucasian 3 Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Country Club Executive Secretary Pages 1 and 2 should be filed vent of Health and Mental Hygid int: If item 27 is marked other? 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Be Julia Sigl John J. Peterson ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7810 Carrleigh Parkway, Springfield, Virginia 22152 Julie Rasmussen - Daughter permit. Pages 1 and Department of Heali Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 04/06/2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD20904 tuguson 23a. Part 1. Enter the disease, or comp colions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 months End Staje Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Hupertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hupercholestrolemia 24a. Was an autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assistea Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 1 Other (Specify) 1 Tes 2 X No Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 🛛 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

10

Saltimore, Maryland 21215-0036

P.O. Box 68760.

Records,

Division of Vital

barles

D43202

3305 N. Leisure World Blvd., Silver Spring,

March 18, 2011

20906

CIME

M.D.,

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charlene Ozanne-Blankfard,

28 2011

31. Date filed (Month, Day, Year)

)	Physicia /Medic Examin	al
	Funeral	

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Exemination to continue the motified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 - For State Registrar	•	partment of H ertificate of L		Reg	No.	11603			
ian cal	1. Decedent's Name (First, Middle, Last) John Campbell Rickwood,				2. Date of Death Month March 2:	2Day 2011	3. Time of Death 7:41 A. M			
ner	4a. Facility Name (If not institution, give street and number 204 Railroad Avenue		East New	Location of Death Market If Under 24 Hrs.	O. Data of Birth	4c. County of Dea	er			
	5. Social Security Number 6. Sex 7. A 1 M 2 F 7. A Usual Residence of Decedent	ge (In yrs. last birthda 68 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, YAug. 24,	1942 Ma	thplace (State or Foreign ountry) ry Land			
tor	10a. State 10b. County Maryland Dorchester	10c. City, Town or East	Location New Market				10d. Inside City Limits 1 X Yes 2 No			
To Be Completed by Funeral Director	10e. Street and Number 204 Railroad Avenue		10f. Zip Code 21631		10g	. Citizen of What C	ountry?			
by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Yes 2 iv Yes 2 iv Yes ar or Dates:	[No	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Spanic Origin) In, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whit				
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	5+) (Given the life	cedent's Usual Occup ve kind of work done o b. DO NOT use retired ck Driver	turing most of worki	Le Le	b. Kind of Business ong Dista ransporta	nce			
To Be Co	17. Father's Name (First, Middle, Last) George Alfred Rickwood				e (First, Middle, Ma zabeth Wi	iden Surname)	CIOII			
	19a. Informant's Name/Relationship (Type. Print) Susan M. Rickwood/Wife		uiling Address (Street	and Number or Run	al Route Number, C	City or Town, State,				
	Susan M. Rickwood/Wife P. O. Box 185, East New Market, MD 21 20a. Method of Disposition 1 Maurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Place of Disposition (Name of cemetery, crematory or other place) East New Market Cem. 3/26/2011 East New									
	21. Signature of Funeral Service Ucensee	leo	22 Name and Addre Zeller Fun 106 Main S	ss of Facility Leral Home treet, Ea	P. O. ast New M	Box 207 arket, MD	21631			
edical Examiner	sht or heart failure. List only on cause in each relations or heart failure. List only on cause in each relations are condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):									
Physician/Me		2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other <i>(specify)</i> _	у		23d. Date of do Month	elivery Day Year			
b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.									
Completed	25. Was case referred to medical			OR Plans of Part		_prior to				
Certification: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpat 27. Manner of Hospital: 28a. Date of Infat 1 Accident investigation 3 Suicide 6 Could not be determined.		e of 28c. Injury M 1	er: 4 Nursing Ho y at Yes 2 No	28d. Describe how	et and Number or F	ecify) Rural Route Number,			
Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manners and manners	of examination and/or								
Me	29b. Signature and title of certifier Mary and	Moore	29c. Licens	e number	290	1. Date signed (Mor				
	30. Name and address of person who completed cause of	death (Item 23a) (Typ	e, Print)	TO NOT	CANO	- (-)	- 24.12			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2<u>011</u> Physician/ Month Arline D. Reid March 21 23:20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's Cheverly Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, 1 □ M 2 🔀 F Months Days Hours Mir Director Jàn. DC <u>577-62-0902</u> Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No DC Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2014 B 37th Street SE 20020 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Black 3 X Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+ Government Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George O. Gibbs Sr. Evelyn Colbert 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20020 Jibreel Reid-El / Son 37th Street SE Washington, DC other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1.
Department of Important: If it Page 1 cemetery, crematory or other place, 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State March 2911 4 ☐ Donation 5 ☐ Other (Specify) Harmony Landover, Maryland 22. Name and Address of Facility Stewart Funeral Home, 21. In pature of Funeral Vervice Linenses Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Enysician, disease or condition Respiratory
Due to (or as a consequence 1): Failure Medical resulting in death) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury Sepsis that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Hypertension, Cerebrovascular Accident, Diabetes Completed 1 Yes 2 No 3 Probably 4 No Unknown peen 24b. Were autopsy findings available prior to completion of cause of Mellitus, Pulmonary Hypertention, Anoxic 24a. Was an has autopsy performed? Yes 2 No death? certificate Encephalopathy and Multiple Decubitus Ulcer. 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ျှ 1 ☐ Inpatient 2 FR/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending Accident 1 Tyes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the ba is of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 224 March 23, 2011

DHMH 17 Rev 7/2009

State

Registrar

9821 Greenbelt Road

Suite 104

20706

Lanham, Md.

30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

MD

32. Registra s Signa

Acquametta L. Frazier,

31. Date filed (Month, Day, Year)

MAR 2 9 2011

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAR 28 2011

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2011 Month March 19 Physician/ Smuckler 12:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5517 Devon Road Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth WI Country) 9. Birthplace (State or Foreign **Funeral** 1 **№** M 2 🗆 F 01/29/1949 367-52-6060 Director 62 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Montgomery Bethesda 1X Yes 2 No 10e. Street and Number 5517 Devon Road 10f. Zip Code 10g. Citizen of What Country? USA ō 20814-1009 Funeral items 23a within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married o, þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Law Real Estate Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ralph Smuckler Lillian Zembrosky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Smuckler-Wife 5517 Devon Road Bethesda, MD 20814-1009 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Grdn of Remembrance 3/22/2011 4 Donation 5 Other (Specify) Clarksburg, MD 21. Signature of Funeral Ser 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 Inc. Blake Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter shock, or heart failure. Lis Interval Between Onset and Death Years only one cause on each line Immediate Cause (Final Physician/ Adenocarcinoma of Lung disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No jo Month Day Year Pregnant at time of death ned by the a edetached f 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 X No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2X No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 I e Hospital or Attending Ph 124 hours after death. e Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 20 Lezze D0023600 March 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 Bruce Kressel, M.D.

MAR 25 2011

31. Date filed (Month, Day, Year)

Box 68760

P.O.

of Vital Records,

Division

Suite 1125 Chevy Chase, MD 20815

5530 Wisconsin Ave.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death 2. Date of Death Month 3 Day 12 Physician/ 2011 8:10P M Alexander W. Sheftell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Montgomery Summerville Nursing Home 6. Sex 1 M 2 □ F Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Months 7/5/1925 Year) Days Min. **Director** Washington, DC 579-20-9051 85 Usual Residence of Decedent f show 10a, State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits irector or 28a-f 1 Yes 2 X No Montgomery Potomac ۵ 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 10537 Tyler Terrace 20854 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, the Medical Examiner Was Decedent Ever in U.S. Armed Forces?

1 IX Yes 2 □ No WWII If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 X Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify. White "natura!", Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Broadcaster Radio & Television 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Harry Sheftell Sonia Wolf Lye 1 and 2 sh.
Lye 1 and 2 sh.
Lye 1 and 2 sh.
Important: If item 27 is m.
any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Sheftell - Wife 10537 Tyler Terrace Potomac, MD 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Memorial Park 3/15/2011 Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility National Funeral Home 7482 Lee Highway Falls Church, VA 22042 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Alzheimer's Dementia Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Anterior Chest Mass - Tissue Diagnosis Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 V No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗓 Natural 5 Pending Accident work 2 No Investigation 6 Could not be Completed filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cept 29d. Date signed (Month, Day, Year) D25818 3/14/2011 30. Name and address of persor ho completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Sean Dwyer, MD. 31. Date filed (Month, Day, Year)

MAR 25

Box 68760

P.O.

Records,

Division of Vital

5454 Wisconsin Ave., Chevy Chase, MD 20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23e Per Phy G915 5/19/2011 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2^{Day} MARCH 20^{rear}1 WHITNEY STAVER 9:17P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY 5. Social Security Number Birthplace (State or Foreign Country)
 VA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ☑ M 2 □ F Months Days Hours Min 02/27/1948 **Director** Yrs 213-50-3957 63 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD MONTGOMERY **BETHESDA** 1 🗆 Yes 2 🗹 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6210 STARDUST LANE 20817 USA within 72 hours after death . Was Decedent Ever in U.S. Armed Forces?

1 Ves 2 No 1968 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>۾</u> 1 Never Married 2 Married If Yes, Give Year or Dates. 1974 1 ☐ Yes 2 I No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the BUSINESS OWNER BARBER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I tem 27 is marked o မ PREBLE STAVER ISABELL GRAYSON WHITNEY other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA KENNEDY/SPOUSE 6210 STARDUST LA., BETHESDA, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place)
STAUFFER CREMATORY 3/25/2011 20a. Method of Disposition Page 1 a 20c. Location - City or Town, State permit. Page 1 and Department of N Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State FREDERICK, 4 ☐ Donation 5 ☐ Other (Specify) MD 4 ☐ Donato...

21. Signature of Jungral Service License 22. Name and Address of Facility P.O. HILTON FUNERAL HOME BARNESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ CARDIAC ARREST disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami ATHEROSCLEROTIC CORONARY ARTERY DISEASE Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> DYSLIPIDEMIA 2 No 3 Probably XX Unknown Completed TOBACCO ADDICTION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? certificate 1 ☐ Yes 2 ☐ No Yes the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 1 No 1 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \(\text{Yes} \) 2 \(\text{No} \) Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 03/22/2011 40476 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records,

Marcet 21, 2011 (2117) 917 PM

NW, #316, WASH.,

DC

3301 NEW MEXICO AVE.,

32. Registrar's Signature

31. Date filed (Month, Day,

RAMIN OSKOUI,

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ ^{Day} 2011 Month Esther Snyder March 27. 6:40 A^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Sandy Spring Brooke Grove Nursing Home Montgomery Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Days Hours July 21 Pennsylvania **Director** Yrs 190-14-5522 85 Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Tes 2 No Maryland Sandy Spring Montgomery 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? event, the Medical Examiner must be 23a Funera 18131 Slade School Road United States 20860 items ? 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ò b 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced ^{Specify:}Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) -12-Bookkeeper Automotive Supply Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Samuel Feder Eva Gesundheit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and E. C. Department of Health an Important: If item 27 is ... initury or other tra William Snyder - Son 1902 Flowering Tree Terrace Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Garden March 29, 2011 Falls Church, VA Signature of Funeral Service Licensee Jefferson Funeral Chapel 22. Name and Address of Facility 5755 Castlewellan Drive Alexandria, VA 22315 MY Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and Death years + Immediate Cause (Final disease or condition resulting in death) Physician/ Dementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or se a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I page 2 autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? Be completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 🛛 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 within 2 To the only one) 29c. License number 29d. Date signed (Month, Day, Year) D0035045 March 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18109 Prince Philip Drive #200 Olney, MD 20832 Philip G. Henjum, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Nor 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 Month March 23, Inez L. Stovall 1454 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y June 14, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔼 F Months Days Hours Min. Yrs. 1918 Director 92 255-34-0863 Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Silver Spring 1 X Yes 2 ☐ No Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 20906 United States 12602 Farnell Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ō þ 1 Never Married 2 Married 1 ☐ Yes 2 A No Specify: Specify: Black "natural" Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 fal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private 3rd Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked of r other traumatic ever ၉ Maude Proctor Jesse Lenon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau # 103 Hyattsville, Md. Joseph T. Stovall - Son 5612 Cypress Creek Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State April 2011 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland Ft. Lincoln 21. Signature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Part buter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in leart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Acute Cardio Pulmonry Arrest Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, Due to (or as a consequence of) If any, leading to immedicause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Exam Hypertension that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical History of Deep Vein Thrombosis IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 1 Yes 2 2 9 Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ he Funeral Director; After this opleted filled in by the funeral direction 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 XNatural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nuss Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Felix Sokolsky
31. Date filed (Month, Day, Year)

MAR 2 9 2011

11125 Rockville Pike

D46364

Chevy Chase, Maryland

March 25, 2011

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	hysicia	an/	Decedent's Nam	e (First, Midd	le,Last)					-		2.	Date of De		Yea		3. Time of E	Death
Medical	Exami	ner	Milton										March 2	2, 201 ⁻	1		0100 h	rs
			4a. Facility Name (Peninsula F		on, give street and ledical Center	,			1 '	y, Town, or Lo is bury	ocation o	of Death			c. County of Vicomic			
Fu	ineral		5. Social Security N	Number	6. Sex	7. Age (I	n yrs. las	t birthday)	lf Ui	nder 1 Year	If Unde	r 24Hrs.	8. Date of I	Birth (MM	/DD/YYYY		nplace (State	e or
Di	rector		215-58-	-6171	1 X M 2 F		58	Y	rs. Mor	nths Days	Hours	Min.	For			Foreign Cou		MD
	A		Usual Residence o								l					J		
	OW Any		10a. State	10b. County		110		own or Loc									10d. Inside	
ryland	28a-f show	ģ	10e. Street and Nu		comico		Mar	de1a		Ings Zip Code				10a Cit	izen of Wh	hat Cour		2 []
he Ma	or 28 ified a	Director	25886 Delmar Road					21837						rog. On	US		чу:	
hours after death with the Maryland	ns 23a or 28a-f sho be notified at once.		11. Marital Status	стшат		ecedent Eve	er in U.S.	13. V	Vas Dece	edent of Hispa	anic Orig	jin? (Spec	ify Yes or I	No-			an Indian, E	Black,
death	or iten	Funeral	1 Never Marri	ed 2 M	larried Armed	Forces?	No	If	Yes, spe	cify Cuban, I	Mexican,	Puerto Ri	can, etc.)		White, etc.			
after		à	3 Widowed		orced If Yes, Give Y					2 🔀 No					Specify:		hite	
hour	Exan	ted	15. Decedent's Ed Elementary/Seco		cify only highest g	rade comple (1-4 or 5+)	eted) 1			ial Occupatio vorking life. D				16b.	Kind of Bu	usiness/lr	ndustry	
)36 thin 7	cdical	Completed	12	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Comage	(1-4-01-01)		ра	ne1	operat	tor				nv	1on	compa	nv
5-0036 led within 72	Hygiene. d other than "natural", the Medical Examiner		17. Father's Name	(First, Middle	, Last)							's Name (F	irst, Middle	e, Maider				
<u>5</u> 3	rke vent	Be			ey Shiles	<u> </u>						adie						
MD 2	Department of Health and Mo Important: If item 27 is m: injury or other traumatic c	٤	19a. Informant's Na		,	+1				ss (Street			_		_			
and 2	fealth frem 2 fraun		Michel e 20a. Method of Dis	position				ce of Disp	osition (N	-Lynn lame of ceme			Delma Date			1875 - City or	Town, State	
Baltimore,	nt of I		1 X Burial 2			from State	l	matory or o	•	•				۔ ا				
altin	ortme		4 Donation 5 21. Signature of Fu				Fir	22.	Name a	metery nd Address o	of Facility	,		III SI	narpt	own,	Mary.	Land
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	sician edical		23a. Part I. Enter the failure. List on	ne disease, or ly one cause	complications that on each line.	caused the	death. D	o not enter	the mod	le of dying, s	uch es ca	ardiac or re	espiratory a	arrest, sh	ock, or he	art		ate Interval Onset and
	niner		Immediate Cause (or condition resulting					ies									De	ath
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executed	nd transit	1	- CVOINS TOSCHING III	dodiny Lust	d	·												
	attending physician and for use as the burial - tran	Physician/Medica	UNPENDED		AMENDE)												
Box 68760, e death certificate be	g phys the bu	₹ Me	IF FEMALE: 23b. Was decedent	as decedent pregnant in the											ν			
x 68	use as	Ciar	past 12 months	5?	4 Pre	gnant at time	e of deat		etal dea Other (S)		Ectopic	: pregnanc	у	ļ	Month	D	ay	Year
B B	å å	hys	1 Yes 2 1		known 9 Unk													
Division of Vital Records, P.O.	s been signed by should be detach		Part II. Other signi	ficant condit	tions contributing	to death bu	it not resi	ulting in the	underlyi	ing cause giv	ven in Pa	rt I.					he cause of ably 4	
duires	en sig uld be	Completed by								<u> </u>			24a. Wa				opsy finding	
SOFC law re	2 5	nple											aut	opsy form <u>ed</u> ?	l r		ompletion of	
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ital sician	After this certificate funeral director, page	Be	25. Was case reference examiner?		Hospital:	Inpatient	2 7 F	R/Outnatie	nt 3	26.Place o		(Check onl Nursing I		Posid	ence 6	Other		
of V	fter th	P P	1 Yes 27. Manner of Deat	2 No	28a. Da	te of Injury hth, Day, Year) 2, 2011		8b. Time of		28c. Injury		? 28	d. Describ	e how in	jury occurr	red		
ion tendir	eath. the fu	Certification:	1 Natural 2 ✓ Accident	5 Pend	ding Mar 2	2, 2011 ****	٥	0002 hrs		1 Ye	s 2 🗸	No Di	iver aut	o fixed	object o	collisio	n	
VISION AT	Direct Direct In by	E C	3 Suicide	6 Coul	Id not be 28e. Pla	ace of Injury	- At hom	e, farm, str	eet, facto	ory, office bui	ilding, et	c. 28	or Town		and Numb	er or Ru	al Route Nu	mber, City
Spital	neral filled	S	4 Homicide			y) Local							357 Norm	s Twille			Springs, M	MD
Division of Vital Records, P.O. Box 68760,	within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page		29a. Certifier 1 (Check only one)	Certifying Pi	hysician: To the b miner: On the basi	est of my kn s of examina	nowledge ation and	, death occ	urred at tation, in	the time, date	e and pla death oc	ice, and du	e to the ca	iuse(s) a	nd manner	r as state	ed.	
Tet	To To	Medical	29b. Signature and		and manner	stated.				29c. License							th, Day Yea	r)
			M	//	/_	/	15			O.C.M					rch 23,		.,,,	,
	MR	}	30. Name and addr	ess of person	who completed ca	use of death	h (Item 2	/ 3a)										
lox	14.0		Russell Alex	kander MD). Assistant				1 Penr	Street, E	3altimo	re, MD	21201					
	St	ate	31. Date filed (Mon	A Pay, Year	2011 32.1	egistrar's S		1. 60	uk									

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State of Maryland / Department of Health and Mental Hygiene	4		4.0	-	4

Damian Thoma	s Sr	nith 1- For State Registrar	State of Maryl		artment of rtificate of		nd Mental	, ,	D N-			
Physic Medical Exam		1. Decedent's Name (First,	Middle,Last)					2. Date of De Month March 30	Day Year	3. Time of Death 1037 hrs		
		4a. Facility Name (if not ins 18415 Pretty Boy	titution, give street and n		,	b. City, Town, o	or Location of De		4c. County of Baltimore	f Death		
Funeral Director		5. Social Security Number 216-19-522	6. Sex	7. Age (In yrs.	• *	If Under 1 Ye Months Da		⁄lin.		9. Birthplace (State or Foreign Country) PA		
v any		Usual Residence of Decede 10a. State 10b. Co	ent		, Town or Locati			12.	0, 1909	10d. Inside City Limits		
th the Maryland 23a or 28a-f show notified at once.	Director	MD Ba	ltimore		P	arkton 10f. Zip Code		T	1 Yes 2 X No 10g. Citizen of What Country?			
15-0036 filed within 72 hours after death with the Maryland I Hygiene. 24 other than "aatural", or items 23a or 28a-f sho 5. the Medical Examiner must be notified at once.	Funeral Di	18415 Pre 11. Marital Status 1 X Never Married 2		cedent Ever in U	.S. 13. Was		2112 ispanic Origin? (an, Mexican, Pue	Specify Yes or N	U . S . A	American Indian, Black,		
ırs after dea ural", or it miner mus			Divorced If Yes, Give Yas	2 X No ar	1	Yes 2 N			Specify:	White		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed by	Elementary/Secondary (0			during mo	st of working life waller	e. DO NOT use r	or work done retired)	16b. Kind of Busi	ruction		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Mid Milton E.	Smith				Ann I	Marie B	Maiden Surname)			
MD 2. nd 2 should saith and M em 27 is m	٩	19a. Informant's Name/Relate Ann Marie 20a. Method of Disposition			1841	3 Pret	ty Boy	Dam Rd		on, MD 21120		
Baltimore, MC permit. Pages I and 2 sl Department of Health as Important: If item 27 injury or other trauma		1 Burial 2 X Creme 4 Donation 5 Othe		om State Cr		n Dire Vice	ct Ap	pate r. 6, 2011	York,	City or Town, State		
		21. Signature of Funeral Ser	1-Wen		24	N. Se	cond St	t., New	r Freedo:	Mortuary, Inc. m, PA 17349		
Physician /Medical :xaminer		23a. Part I. Enter the disease failure. List only one ca Immediate Cause (Final dise or condition resulting in deat	ease a. Carbon		de Toxi				rest, shock, or hear	t Approximate Interval Between Onset and Death		
	Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of	<u></u>			_				
ared d ansit	Examine	cause. Enter Underlying Ca (Disease or injury that initiate events resulting in death) La	ed ^{C.}	consequence of):							
	Medical	X UNPENDED IF FEMALE:	AMENDED	23a,27		per me g	g914 4-1	2-11 vt	Lood Bata of the			
Box 68760 e death certificate I the attending physical ed for use as the bu	hysician/I	23b. Was decedent pregnant past 12 months? 1 Yes 2 No 9	in the 1 Live b	irth ant at time of dea own	2 Feta	I death 3 er (Specify)		nancy	23d. Date of de Month	Day Year		
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ion of Vital Records, P.O. Box 6876(tending Physician: The law requires that the death certificate eath. ior: After this certificate has been signed by the attending phys the funeral director, page 2 should be detached for use as the b	Completed	25. Was case referred to med	tical			00 Diagram		1 Yes	psy price dea	re autopsy findings available or to completion of cause of ath? Yes 2 No		
Vital I hysician:		examiner? 1 ✓ Yes 2 No	Hospital:	npatient 2	ER/Outpatient		Other Nurs		Residence 6	Other: Scene		
ion of tending Pheath. tor: After the funeral	ation: T		28a. Date of (Month), rending from the stigation are stigation.	Day,Year)	28b. Time of Inju Ed 10:28		ry at Work? Yes 2 X No	28d. Describe I	how injury occurred			
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	$\alpha \vdash$	3 Suicide 6 X C		of Injury - At ho	me, farm, street, dence	factory, office b	uilding, etc.	28f. Location (S	Street and Number of	Pretty Boy Md.		
8 - = >	edical	one) 2 Medical E	ng Physician: To the best of my knowledge, death occurred at the time, date and Examiner:On the basis of examination and/or investigation, in my opinion, death and manner stated.					ate and place, and due to the cause(s) and manner as state				
		29b. Signature and title of cer famely	withall, M	9		29c. License O.C.			29d. Date signed March 31, 20	(Month, Day, Year)		
Ø l	[3	30. Name and address of pers Pamela E. Southall,		e of death (Item 2 Medical Exam	,	Penn Street	, Baltimore,	MD 21201				
Sta Registr		31. Date filed (Month, Day, Ye.	1 2011 32.	porar Signatur	bar	الما						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day FAN 2:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MeDia DARK DAWN WASHINSTER CONFR 5. Social Security Number Age (In vrs. last birthday) If Unde If Under 24 Hrs. 8. Date of Rirth 9. Birthplace (State or Foreign Funeral 1 - M 2 XF Months Feb. 21. Hours 182-22-5892 Pennsylvania Yrs Director 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important if them 27 is marked other than "natural". A state of the marked other than "natural". 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington county Hagerstown 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1061 Matthew Court 21742 U.S.A. 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Specify: Completed 3 X Widowed 4 ☐ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Earl Baish Helen G. Sprow Baish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rick Toms-son 14401 Marsh Pike Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 3-30-2011 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home <u>Fastern Blvd</u>. North Hagerstown. 23a. Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final 5457018 Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner PUMONON DISERSO OBSIEVE, YE STAR Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month Year Day been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 □ Unknown DIRUMONIC 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autops, performed 2 No certificate 25. Was case referred to medica director, 26. Place of Death (Check only one) Be examiner? Other: ျှ ER/Outpatient 3 DOA 1 Nnpatient 2 -4 Nursing Home 5 Residence 6 Other (Specify, this within 24 hours atter ueau...
To the Funeral Director: After thi funeral Manner of Death Certificate: 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only one Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date sig 29c. License number ned (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VH-12

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death RegistraMFND#7perFH, 3/28/11; BWJ, McCo Decedent's Name (First, Middle, Last) 2. Date of Death Month **3** Physician/ Day 24 Year 11 LIEU THI TRUONG 11:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 57 Months Hours Director 58 12/20/53 218-29-1819 Vietnam Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring Montgomery 1 Yes 2 No Maryland | 10e. Street and Number r items 23a or iner must be n 5 10f. Zip Code 10g. Citizen of What Country? with Funeral 20904-1845 12408 Pretoria Drive United States within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. the Medical Examiner Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 'natural", Specify: Asian Completed 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) District Photo Inc. Specialty Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ೭ Nghiep Truong Demit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. traumatic Nham Do 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Laurel, Maryland 20723 9617 Dapper Town Row Michelle Ho - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🕱 Removal from State 4/4/11 Vietnam 4 Donation 5 Other (Specify) Nghia Trang Thanh 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Arlington Funeral Home 3901 North Fairfax Drive Arlington, VA 22203 c0412 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healt failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) **Breast Cancer** Years Medical Due to (or as a consequence of) **Examiner Brain Metastases** Months Sequentially list conditions, if any, leading to immediate cause. Eller Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam executed Months Liver Metastases and tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Months **Bone Metastases** Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death Month Day Year the 9 Unknown Unknown þ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pleural Effusions, Malignant 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of has page performed? death? certificate Yes 2X No 1 Tes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After within 24 hours after death.

To the Funeral Director: After Completed filled in by the fune 5 Pending (Month, Day, Year) 1 X Natural work' М 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier only one) 29b. Signature and title of certifie Supanich, Rom MI Barbara 0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Supanich, MD 1500 Forest Glen Road Silver Spring, Maryland 20904

DHMH 17 Rev 7/2009

State

Registrar

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Registrar

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THOMPSON

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division of Vital Records,

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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 24

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend 26,29c per phys, Maryland / Department of Health and Mental Hygiene
Registrar DOR, 3/30/11, LDB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0037 Rebecca Waters march 2011 na Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Easton Mamorial Hospital at alboi Eastin 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date of L... (Month, Day, 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🖫 F Min. Months Days Hours Director Maryland 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No turlock 10f. Zip Code ò 10e, Street and Number 10g. Citizen of What Country? items 23a Funeral 21643 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. b þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates "natural" 3 ₩ Widowed 4 □ Divorced Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Aide Nursing traumatic event, Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s
copartment of Health as
Important: If item 27 is any injury or other to Jackson Street HUYlock, Maryland 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State Hurlock, MD. Cemetery 4 ☐ Donation 5 ☐ Other (Specify) terans Henry Funeral Home, RA. 21. Signature of Funeral Service Licensee St. Cambridge, M.D. 2/6/3 10 washington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Enterocutanins disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner days Cancu Sequentially list conditions, if any leading control of cause. Enter Underlying Cause (Disease or linjury Examiner Due to lor as a consequence of Obstructive hrinic The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 Unknown detached the Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ be Records, 1 → Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 2 🗆 No certificate Yes 2 No 1 Yes Division of Vital Hospital or Attending Physician; completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 2 No 2 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: s after death. I Director: After t 28d. Describe how injury occurred 1 A Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29c. License number**D**65846 29b. Signatur d title of certifie 28 SURGEON address of person who completed cause of death (Item 23a) (Type, Print) 21601 EASTIN LANE BATLEY 545 DATC HMANS ERRY Registrar's Signature 31. Date filed (Month, Day, Year, State MAR 30 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March **Physician** a Ann Windsor 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Cambrida orchester General Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Aug. 4, . Social Security Number Age (In vrs. last birthday) **Funeral** Year) 1941 Months Hours 1 □ M 2 F Days 216-40-3755 69 Aug. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County show 10a, State 10c. City. Town or Location MD Dorchester Madison other traumatic event, the Medical Examiner must be notified Director 1 □Yes 2¶ No 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 1057 Taylors Island Road 21648 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 ☑ No Specify. Specify: þ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 is marked ot Lewis Leonard King Mamie Barrack 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene A. Windsor husband 1057 Taylors Island Rd., Madison, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition injury or 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Old Trinity Churchyard 3/30/11 Church Creek, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee any 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner sequentismy fiet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed Due to (or as a consequence of): burial physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown þ s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed this certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28h Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

29b. Signature and title of certifie

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300

Byrn St Registrar's Signature

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Registrar

29c. License number

165528

21613.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** unic 24, 2011 3:50 P M March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Forestville Health/Rehabilitation Ctr District Heights Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 🖾 F 23, 1925 Director 578-48-3383 85 Maryland Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exprince must be notified at Director 1 X Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1616 S. Street SE 20020 Funeral <u>United States</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐Yes 2 XNo Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Data Entry Operator Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev Elsie Cooper-Offutt ဥ Dennis Cooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1906 S Street SE Washington, DC 20020 Rita J. Williams - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

■ Burial 2

□ Cremation 3

□ Removal from State March 31, 4 Donation 5 Dother (Specify) 2011 Suitland, Maryland Lincoln 21. Signature of Fundad Service Liounce 22. Name and Address of Facility Stewart Funeral Home, Inc. 20019 4001 Benning Road NE Washington, DC Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hythmas **Physician** disease or condition resulting in death) /Medical Due to (or as a con a guence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an iis certificate has director, page 2 s autopsy To the Hospital or Attending Physician: The performed 1 ∐Yes 2 No 1 ☐ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To After th funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28h. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation ours after death, neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. within 2 To the I 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, MAR 2 9 2011 ledewater Colony

32. Registrer's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001

march 24 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month Physician Williams 2011 /Medical Marc 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore City 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖁 F Months Days Hours Min. (Month, Day, Year, 8/9/1964 46 579-92-3395 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Virginia Chesapeake 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 408 Niles Court 23322 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖁 No White ð 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mother At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Earl Buckler Elizabeth Jane Wolfe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason E. Williams/Husband 408 Niles Court, Chesapeake, VA 23322 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗐 Burial 2 Cremation 3 Removal from State Resurrection Cemetery 3/30/2011 | Clinton, Maryland 4 Donatia 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur 6160 Oxon Hill Rd. Oxon Hill, 1. Enter the diseas Enter the disease, or complications ck, or heart failure. List only one cause had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia disease or condition /Medical resulting in death) Due to (or as a consequence of) **Examiner** Myeloid Leukemia Sequentially list conditions, and a light in a light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed detached for use as the burial-trail Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death 5 Other (specify) been signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 TYes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred I Director: After the funeration by the funeration 1 X Natural 5 Pending investigation Injury 2 Accident 1 Yes 2 No 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor

To the Fune

completely fi (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number RES-000 25, 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 9 2011

32. Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ White Mary Loraine March 21:34 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 29833 Deer Harbour Drive Salisbury Wicomico 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏋 F Months Days Hours Min. (Month, Day, Year) 04/29/1933 Country) Indiana 77 Director 316-30-5424 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29833 Deer Harbour Drive 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates white Specify. 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) homemaker domestic Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental I Important. If item 27 is marked o any injury or other traumatic eve မ Sydney Delmont Shaffmaster Esther Palmatier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
29833 Deer Harbour Dr., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type, Print) Edward C. White/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 3/25/2011 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Salisbury Crematory Signature of Funeral Service Licensee Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to immediate Examine Due to (or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? After this certificate 1 Yes 2 No Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical B 26. Place of Death (Check only one) examiner : Hospital: 2/ No Other: 욘 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Aurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certife 29d. Date signed (Month. Day, Year) 00599 MANN, M.D. 3 2185 o completed cause of death (Item 23a) (Type, Print) Charles 30. Name and addr 7043 Princess Werner MAR 28 Registrar

100	/Medic Examin Funeral Director	ar eal
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Emprel Disoctor

Physician /Medica Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	For State Of Ivial	yland / Depa <i>Cer</i>	rtment of He tificate of D			eg. No.	11629		
ician dical	Decedent's Name (First, Middle, Last) ELLA JEAN WHITTINGTON	-BURNETT			2. Date of Death	5, ^{Day} 011 Yea	3. Time of Death 12:46AM		
niner	4a. Facility Name (If not institution, give street and number) 3644 LIGHTNER COURT 5. Social Security Number 095-24-5912 6. Sex 1 M 2 M F	(In yrs. last birthday) 79 Yrs.		DORF If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day)	4c. County of De CHARLE 9. B			
		10c. City, Town or Loc	eation WALDO	DF			10d. Inside City Limits 1 □ Yes 🗶□ No		
al Director	MD. CHARLES 10e. Street and Number 3644 LIGHTNER COURT		10f. Zip Code 2060		10g. Citizen of What Country?				
once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No Yes 2 □ No Yes 2 □ Yes Give Year or Dates:		Vas Decedent of His i Yes, specify Cubar □Yes 2 🕅 No						
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 2 5 +	(Give)	lent's Usual Occupa kind of work done du DO NOT use retired) NISTER	NON DEN	os/industry OMINATIONA CHURCH				
To Be (17. Father's Name (First, Middle, Last) JAMES PATTON WHITTIN	LOUISE							
	19a. Informant's Name/Relationship (Type. Print) ELISSA McDANIELS-DAUGHT	ER 3644	LIGHTN	ER CT.	WALDOR	RF, MD . 20	602		
9	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		ILL MEM	.CEMETE		•	EL HILL, N.		
Succe	21. Signature of Funeral Service Licensee M0047	(/ R	AYMOND I	FUNERAL	SERVIC ND 2064	E,P.A.	Approximate Interval Between		
al Examiner	Sequentially list conditions, if any, leading to fine to force a cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of): consequence of):		1		de			
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 1¢ months? 1 □ Yes 2 No 9 □ Unknown d		23d. Date of delivery Month Day Year						
þ	Part II. Other significant conditions contributing to death but	not resulting in the un	derlying cause give	n in Part I.		I tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Worknown			
Completed	25. Was case referred to medical					y prior t ned? death 2 No 1 □ Y	autopsy findings available o completion of cause of ?		
ation: To Be	examiner?	t 2 ER/Outpatien 28b. Time of Injury	t 3 DOA Othe	4 LI Nursing Ho	me 5 Reside	only one) Residence 6 □Other (Specify) cribe how injury occurred			
Certification:	4 Homicide determined building, etc.				City or Town	n, State)	Rural Route Number,		
Medical	29a. Certifier Certifying Physician: To the best of (Check only one) 2 Medical Examiner: On the basis of and manner state 29b. Signature and title of certifier	examination and/or inv		pinion, death occurr	red at the time, d	ate and place, and o	lue to the cause(s)		
	30. Name and address of person who completed cause of dea	ath (Item 23a) (Type I	D).	835)	29d. Date signed (Month, Day, Year)			
State	31. Date filed (Manth Day, Year) 32. Registrar	705	Lat	(c)a	m	0 70	646		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 70b Per FH G9144/25/2011JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Non 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 Physician/ 7:15 AMM Medical 4a. Facility Name (if not institution, give street and humber) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Goodwill Mennonite Living Comm. Garrett Grantsville 9. Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** ^{ear)}19<u>29</u> Months Days Hours Min. Sep 23 Director 480-30-3568 81 Usual Residence of Decedent or 28a-f show e notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Garrett Grantsville 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be by Funeral 21536 891 Dorsey Hotel Rd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify Completed 3 XWidowed 4 Divorced white Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Garnet (Lee) Cornish Woodley Cornish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 2331 Pleasant View Rd. Adamstown MD 21710 Merri Jo Wright daughte item 27 Page 1 and 2 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place)
Arlington National Cemetery 7/28/2011 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State VA Arlington 4 Donation 5 Other (Specify) Signatur - of Funeral Servi - Licensee 22. Name an Scarpein Fullieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part //. Erfter the disease, or complications that values shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betweer Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes ∠¬
9 ☐ Unknown a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📜 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Tyes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 🗌 No Accident Suicide Investigation s after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) D 26650 s of person who completed cause of death (Item 23a) (Type, Print) Oaklan

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State Registrar 31. Date (iled (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 30 Frank James Walchuck, Jr. March 8:07A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Baltimore 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Country) 1 🙀 M 2 🗆 F Months Days Hours Min Director 218-40-1129 69 Usual Residence of Decedent or 28a-f shov notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Freeland 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 21319 Middletown Road 21053 U.S.A. er than "natural", or items the Medical Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates <u> 1</u>363 Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland Dept. Elementary/Seconday (0-12) 12 College (1-4 or 5+) mit. Page 1 and 2 should be filed within sartment of Health and Mental Hygiene. octant: If item 27 is marked other tha injury or other traumatic event, the N Transportation Highway Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Stella Nawrocki Frank James Walchuck, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21319 Middletown Rd. Freeland, MD 21053 Marjorie J. Walchuck/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Pine Grove U.M.
Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkton, MD 2011 22. Name and Address of Facility J.J. Hartenstein Mortuary, PA 17349 24 N. New Freedom, Second St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician acute myocardial infarction <5 minutes disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** huperlipidemia lear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in listed events) Examine Hospital or Attending Physician: The law requires that the death oertificate be executed 24 hours after death. attending physician and for use as the burial-transit hupertension that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year signed by the a d be detached fi 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy performed page 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 🗹 No Hospital: မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 5 Pending injury 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0065809 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N Greater Raltimore Medical Conter Gerard Paras Dimaano 31. Date filed (Month, Day, Year) Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mohit Clyde Raymond Yutzy Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cumberland Western MD Regional Medical Center Allegany If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** PA Country) 92 215-18-8039 **Director** 08 Usual Residence of Decedent ı "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 🗌 Yes 2 🗙 No Meyersdale PA Somerset 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number U.S.A. 15552 3609 Greenville Road 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates.
194 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 1941 Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.

item 27 is marked other than "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 1945 3 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Kaiser Refractories Carpenter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evora Miller Yutzy ည John Yutzy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 240 Walters Mill Rd Somerset PA 15501 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr <u>Joyce Wright</u> daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Meyersdale, PA <u> Greenville Cemetery |</u>4-9-2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sowers Funeral Home, P.A. 21. Signature of Funeral Service Licensee 60 W. Main Street Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician/ Atheroelerotic Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a nonsequence of): as the burial-transit Due to (or as a consequence of) attending physician Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 2 1 X Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 1 within 2 To the 1 only one 29b. Signature and title of certified Nonwehrs 00055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bishop Walsh Road Camberland Registrar's Signat State

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ March 25, Day 2011 Year 12:25 Gilda Cecilia Zamora Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death
Montgomery **Examiner** Silver Spring 15307 Merrifields Court 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ec. 6, 1940 Cu<u>ba</u> 1 🗆 M 2 🕱 F Months Days Hours Min Director 220-60-0837 Dec. Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Silver Spring Montgomery 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a USA 20906 15307 Merrifields Court 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 White 1 X Yes 2 □ No Specify: Cuban If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Health Mental Health Tech. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Gilda Marten permit. Page 1 and 2 should be fil. Department of Health and Mental Important: If item 27 is marked any injury or other traumatic events. 2 Benjamin Odio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15307 Merrifields Court, Silver Spring, MD 20906 Carlos E. Zamora/Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 27 March 2011 Metropolitan Crematory Alexandria, VA 21. Signature of Funeral 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. MD 20901 Silver Spring, 500 University Blvd. W, 23a. Pard 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final Onset and Death Physicians a Irreversible Dehydration Medical resulting in death) Due to (or as a consequence of) Examiner 3 years <u> Metastatic Breast Cancer</u> Sequentially list conditions If any, leading to immediate cause. Enter Underlying Dire to (or as a consequence of, Exami ξŊ Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-tr Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No 5 Other (specify) Month Day Year Pregnant at time of death bed 1 the signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' certificate 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5\(\mathbf{X}\) Residence 6 \(\sum \) Other (Specify) 1 Yes 2X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After Z Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 24 hours after death Funeral Director: A Investigation М 1 Yes 2 No completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAR

28

2011

. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) Type Print)

James E. Wilson, Jr, M.D. 10400 Connecticut Avenue, Kensington, MD 20895

29c. License numbe

Mary and

29d. Date signed (Month, Day, Year)

2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia	n/	Registrar 1. Decedent's Name Edgar	e (First, Middle, L	Last)	Be11:		er linicate or	Deatri	T	2. Date of De	D	av Vaa	3. Time o		
Medic Examin	al	4a. Facility Name (if		give street and number					of Death	April	8, 2011 5:47 4c. County of Death				
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and Instructure II is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (f		Ве	ellido)		18. Mot		(First, Middle, emia	Maider	Surname) Lazo)		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <u>12:3</u>0 P.™ <u>April</u> Velenovsky Bieneman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Towson <u>Baltimore</u> 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M 2 🕅 F Months Days Hours Min. (Month, Day, Ye 86 Director 213**-**20-8555 Aug. Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🏹 Yes 2 □ No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6004 Clearspring Road 21212 U.S.A. death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic v John Velenovsky Mary Svec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert C. Bieneman (husband) 6004 Clearspring Road Baltimore, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-14-11 Baltimore, Maryland Baltimore National Cem. 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland Levaise 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin nding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year Pregnant at time of death signed by the at d be detached fo Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy performed? Yes 2 No has this certificate • Hospital or Attending Physician: 24 hours after death. • Funeral Director; After this certifica Division of Vital 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 2 🗌 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury EI Investigation 100001 30,201 UN(100.1M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined CO ROHMO 2121 ans Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 1 2 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [For State Ragistrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** William Thomas Bateman April 4. 2011 3:45 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FutureCare North Point Dunda1k Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Hours Min. Sept 15, 1920 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ★M 2 F 245-01-1416 90 North Carolina Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Virginia 1 ☐ Yes 2 No Suffolk Suffolk Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2022 Nicklaus Drive 23435 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 11 Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 √Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Commercial Contractor 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James T. Bateman Brownie Boyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carolyn Yates daughter 1471 Woodall Street Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Comfort Cemetery April 8, 2011 Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 21. Signature of Eune al Service Licensee 130 Fast Fort Avenue Baltimore, Maryland 21230 Approximate Interval Between Onset and Death Survey 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final (sul Physician ioVasar 4 waks /Medical resulting in death) Due to (or as a consequence of): Examiner Maria di Americano malled Sequentially list nondlices if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): the attending physician P.O. Box 68760, Completed by Physiclan/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 □ Yes 2 □ No investigation the t 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 - Homicide Hospitel 29a. Certifier f Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D - 38754 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04-04-2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , GASTERN M.D. 21221 SERM 709 ~ Deneu 32 Registrar's 94

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 04^{Month} Day 2011 SHIRLEY Μ. BEVILACQUA 06 6:25 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TIMONIUM BALTIMORE STELLA MARIS Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Months Days Min 01-16-1938 KENTUCKY Director 73 401-48-0530 Usual Residence of Decedent 28a-f show 10a. State items 23a or 28a-f sho her must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣No MD HARFORD HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funera 40 ROBINHOOD RD. LOT 728 21078 U.S.A. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or iter edical Examiner 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give ò Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☒ Divorced Specify: WHITE Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th DOMESTIC DOMESTIC permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SALLEE DEBRA HOWARD 2011 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RANDALL TROUT/SON W. 18 CHARTER OAK GROTON, CONNECTICUT 06340 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State METRO CREMATORY 4 Donation 5 Other (Specify) 04-11-2011 BALTIMORE, MD Signature of Fundral Service Libert WILLIAM C. BROWN COMM. F/ 321 S. PHILADELPHIA 'H P.A.-HARFORD BLVD. ABERDEEN. Vala MD 2110001 a. Part 1. Enter the disease. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ESOPHAGEAL CANCER Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury and trar that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Vital Records, P.O. Box 68760 nding p as SHIRLEY BEVILACOUA IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law has page 2: autopsy death? certificate 1 Tes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Yes 70 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE this of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? Division after death Investigation Accident the Suicide Director: 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 201 person who completed cause of death (Item 23a) (Type, Print) 30. Name and add JACKIE JONES. CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 Date filed (Month, Day, APR 1 2 2011 Registrar

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215-0036 be filed within 72 hours after death with the Maryland ntal Hygene. ked other than "matural", or items 23a or 28a-f she	ျှင်		ne (First, Middle, Last	b) _ [18.Mother's Nan	ne (First, Middle, M		
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Balti permit. Departu Import		7-	- (S	1		HOPE !	Jone 7	1 STEIN	2 NO 212	17
Physicia			the disease, or componly one cause on e	plications that caused the	death, Do not e			or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medica		Immediate Cause	-	Gunshot wounds (2	2) of torso					Death
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387 rtifica ing ph		23b. Was deceder past 12 month		1 Live birth	2	Fetal death	3 Ectopic pregr	nancy	the second second	Day Year
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Dital of the state	Ë	4 Momicide	determine		Street			or Town, St 3402 Powhata	ate) n Avenue, Baltimore	, MD
Hosi 24 hc	la O	29a, Certifier 1 (Check only		ian: To the best of my kno						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici from letely filled in by the finneral director nase 2 should be deached for use as the hurst.	Medical	one) 2		r:On the basis of examina and manner stated.	ition and/or inve			at the time, date a		
- 31.0	Ž	29b. Signature an	d title of certifier		1		cense number		29d. Date signed (Mo	nth, Day, Year)
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5 V		30. Name and add		completed cause of death		Penn Stroot E	Baltimore, MD 2	1201		
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	State									

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Q Day 20**T** 12:59 PM Claire M. Bartel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Lutherville College Manor Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Mary) and **Funeral** Hours June 14 14927 1 □ M 2 🗓 F 83 219-22-3672 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Timonium 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12261 Roundwood Road 21093 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) C&P Telephone Oustamer Service Surpervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ew မ Boland Margaret John Boland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3406 Kreitler Road Forest Hill, Maryland Marguerite Simms / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Dulaney Valley Mem. Gdns. 4/13/2011 1 $\overline{\mathbf{X}}$ Burial 2 \square Cremation 3 \square Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Signature Licens 22. Name and Address of FacilityRuck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phylician 55 Second my disease or condition Medical resulting in death) Examiner recurrent episodes of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): neumonia Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician; The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Heart Failure physiciar Physician/Medical estive Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month signed by the at be detached for 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 Yes 2 No 2 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes ASSISTER 10 2 - No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spe After this 27. Manner_of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director; Al 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier сотріете (Check 2 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of confifier 29d. Date signed (Month, Day, Year) tem 23a) (Type, Print) 30. Name and address of person who completed cause of death 6 701 31. Date filed (Month, APR 12 32. Regi State 2011 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #10b.cc.20b.cc Per FH G914 4/12/20 FIRST All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ [] | = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Angela Susan Bryan :20 p April 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Gilchrist Hospice Care Center Baltimore Towson 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - F Months Days Hours Min (Month, Day, Year, 212-58-7816 47 Director June 5 1963 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director N/A MD Baltimore XX Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a USA 1903 Hillside Drive 21207 and 2 should be filed within 72 hours after death Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 21 No Specify: Specify: Black "natural" 3 Divorced 4 Divorced ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Saleperson Department Store marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilma Wyche Samuel Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 27 Samuel Bryan - Father MD 21230 1223 W. Ostend St. Baltimore, Department of Healtt Important: If item 2: any injury or other tonce. Saltimore, 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 20b. Place of Disposition Name of PARK MOODITAWN TYMD wn, State Lorraine 4/15/2011 Cem Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Avenue March Funeral Home West Baltimore, 23a. Part 1. Enter the drease, or complications that caus with death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart brilling. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Freact Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Discass or impury that initiated events Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate I 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural iniury work? 1 Yes 2 No 5 Pending 2 Accident
3 Suicide М Investigation Director: 6 Could not be To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Vertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) K125808 lewis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anrelewis, canp St 05 31. Date filed (Month Registrar's Signa State krown Registrar

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Linda Susan Bowles Physician/ April 2011 5:30 au Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death
Washington **Examiner** Meritus Medical Center Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday)
57 vrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Months Days 05/28/1953 212-64-5827 DC Director Usual Residence of Decedent show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Smithsburg 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16 maple Grove Court 21783 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 io Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White Specify: Completed 3 XWidowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Bookkeeper transportation t. Page 1 and 2 should be filed tment of Health and Mental Hy rtant: If item 27 is marked ot 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Patricia McMahon Alfred Edison Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas A. Mongelli/Cousin 1859 Millstream Drive, Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey crem. 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of I-Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4/13/2011 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Poorta Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner osteoungelitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 No ate has been signed by the atte page 2 should be detached for 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate 2 **N**N 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification place of the funeral director, to the funeral director, the funeral director of the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural work?
1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Quo. Docusto? 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IIILE MENICAL CAMPUS ROAD HAGRESTOWN, MD 21742 SOMA, MD Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Delores Lucille Brown Day 201 1 ear Physician/ April 4, 4:20 a M Medical 4c. County of Death
Montgomery 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Takoma Park Examiner Washington Adventis Hospital 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Countro Months 218-38-9752 1 □ M 2 🛛 F 72 Davs Hours Min 12/10/1939 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any hipury or other traumatic event, the Medical Examiner must be notified at any hipury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Prince George' Capitol Heights Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 505 Suffolk Avenue, Apt. 317 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Cora L. Johnson Alfred Edward Brown 19a. Informant's Name/Relationship (Type, Print) / Donnell R. Brown / 19b. Mailing Address (Street and Number or Rural Route Number City or Town State, Zip Code)
505 Suffolk Ave., Apt. 317, Capitol Heights Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State remetery, crematory or other place)
Final Journey Crem. 4/10/2011 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service LicenseeDorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD Marshan Approximate 1203
Interval Between
Onset and Death 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Herry Immyodeficiency Physician/ VIRUS 14 disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts) Examine Due to (or as a consequence of): that the death certificate be executed and tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by anames Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an y pertension autopsy page perform death? rmed? 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 Yes 2 You Other: ည 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending injury 1 X Natural within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. License number 29d. Date signed (Month, Day, Year) 201852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 4203 Welcarshung Rd thattsville MD 20789 31. Date filed (Month, Day, Year, State PR 1 2 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5,19b per inf g9155-3-11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month P^{M} **Physician** 2, 2011 9:52 April Gerhartz Benzinger Maria /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bethesda If Under 1 Year If Under 24 Hrs. Montgomery 5. Social Security Number 6607 Broxburn Drive 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Months 1 □ M 2 🕅 F Yrs. 93 February 18, 1918 Germany Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show d other than "natural", or items 23a or 28a-f shov event, it a Madical Examiner must be notified at 1 ☐ Yes 2X No Director Bethesda <u>Marylan</u>d Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with United States 20817 6607 Broxburn Drive Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates: Specify: ģ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Medicine 5÷ Physician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Mental I Elisabeth Reineke ပ Heinrich Gerhartz 19h Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zin Code)
660 / Broxburn Dr. Bethesda, Maryland 20817
22 Kent Road, Dunkeld, Cautang, South 19a. Informant's Name/Relationship (Type. Print) 2196 Fay Ann Benzinger-Wilson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ot 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 10,2011 Bethesda, Maryland Crematorium, Inc. 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 Months Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatic Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 □ Yes 2 ☒ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cer April 7, 2011 MD33485 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas M. Loughney, M.D. 3301 New Mexico Avenue, NW #232, Washington, D.C. 20016 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 20<u>11</u> April Physician/ 10. 10:03 PM C. Brackin Sarah Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Gilchrist Hospice Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year)9<u>34</u> Months Days Hours Min. 1 M 2 X F Salem. OH Yrs Feb. 301-28-7842 **Director** Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits at 10a. State Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Cockeysville MD Baltimore 10f. Zip Code 10e, Street and Numbe 10g. Citizen of What Country? Funeral USA 21030 203 Dawson Dr. or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12, Was Decedent Ever in U.S. Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White Specify "natural", Completed 3 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) the Medical Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bottomlev Marv Donald Calladine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Church St. PA 17363 Keith Brackin/Son Stewartstown, other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Du Cametery crematory or other place)
Memorial Gardens Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 2011 Timonium, MD 4 Donation 5 Other (Specify) 21. Signature of Fund Sep Lemmon Funeral Home of Dulaney Valley 10 W. Padonia Road Timonium, MD 210 Lice J. Flagle ichael implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art 1. Enter the dis shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 5/ Medical to (or as a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter choorlying Cause (Disease or iinjury Due to (or as a consequence of) as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Pregnant at time of death been signed by the sahould be detached 9 I Inknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown Division of Vital Records, 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s or Attending Physician: The law autops this certificate has death? 1 Tes 2 🗌 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 - Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 1. Natural injury 5 Pending М ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) and title of certifier 29b Signature 29c. License number 29d. Date signed (Month. Dav. Year) tpn1 0011 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 30AM Varnita Booker Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death N/A Baltimore Future Care 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 1 M 2 XF 91 Yrs. 0476377920 Maryland Director 216-24-5816 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3809 Cranston Ave. 21229 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry North Charles (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Dietician Gen. Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beatrice Coleman Lorenzo Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Lambson(niece) 3809 Cranston Ave., Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State on-site Crematory 04/11/11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Josephires Pr. Fac Brown Jr. Funeral Home PA 21217 quelvie 2140 N. Fulton Ave., Baltimore, MD 1. Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or h. eri failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ther Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician. The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated event resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal deal 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 rate has been signed by the a page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 certificate 2 110 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: ပ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work Accident 1 Yes Investigation Director 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Prantiquen To the best of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/20/

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 29d State of Maryland / Department of Bealth and Mental Hygiene 1 | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AP LIL Physician/ 22: 08 CUZTIS COOPER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMURE OF MARYLAND MUNICA CENTER Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 MM 2 🗆 F Days Hours Director WASHINGTON, DC Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Oc. City, Town or Location
REISTERSTOW N 10a. State within 72 hours after death with the Maryland 10d. Inside City Limits Director MD1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral CONEWOOD 21136 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, δ 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK 3 ▼ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important, If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) FEDERAL STANDARD DAN OFFICER Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) BENNIE COOPER, SR. BERNICE FAISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SISTER) 5058 WHETSTONE RD. COLUMBIA, MD. 21044 20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERS 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State BACTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign at re of Funeral Pervice L 22. Name and Address of Facility VAUGHN GREENE FUNELAL SCYS BALTIMORE, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) ANEMIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 29 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 🔲 No been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes မ 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No. 1 💹 Natural 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 124 hours a Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number April 9, 2011 1134446164 MD Grech 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 21201 GOEHNER 22 SOUTH GREENE ST BALTIM LIZE MD NICHOLAS 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

	For State Registrar	State of Maryland	/ Departmer		-	gieng 0 1 1	11648		
Physician/	1. Decedent's Name (First, Middle, La.		Ochinoati	COLDCULT	2. Date of De		3. Time of Death		
Medical Examiner	Elsie V. Carlii		4b. City,	Town, or Location of D	April eath	8 2011 4c. County of Deat	10:50 P M		
	Edenwald 5. Social Security Number 6. S	7.0 (Tow		<u> </u>	Baltimo	re		
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show	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits		
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teath with the Maryland tems 23a or 28a-f sho ter must be notified at Elmoral Director	10e. Street and Number 800 Southerly	Road	10f. Zip	1286		10g. Citizen of What Co	untry?		
death y		12. Was Decedent Ever in U.S. Armed Forces?		ent of Hispanic Origin? ify Cuban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)				
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215-0036 in 72 hours after han "natural", o	15. Decedent's E (Specify only highest gr	ade completed)	16a. Decedent's Usua (Give kind of woilife, DO NOT use	k done during most of	working	16b. Kind of Business	Industry		
d 212 d 212 led within Hygiene. other tha ent, the N	Elementary/Seconday (0-12)	College (1-4 or 5+)	Secretary	Tetil Gay		Federal Go	vernment		
Note, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland to 6 Health and Mental Hygiene. "It item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at To Re Completed by Funeral Director	i 17. Father's Name (First, Middle, Last) Hegreve Tokunage	a		l -	Name <i>(First, Middle,</i> Swenson	, Maiden Surname)			
Marylal 2 should be th and Ment. 27 is market traumatic e	19a. Informant's Name/Relationship (7	ype, Print)	-				ity or Town, State, Zip Code)		
Te, N 1 and 2 1 Health item 21	James Carlin / So	20b. Plac	ce of Disposition (Nan	ne of	entrevill Date	e, Maryland 20c. Location - City or	20120 Town, State		
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or othe once.	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	i i cilioval ilom clate	netery, crematory or o Ion Park Ceme		12/2011	Baltimore,			
	21. Signature of Funeral S				uck Towso Towson, M	n Funeral He arvland 21	ome, Inc. 204		
R	23a. Part 1. Enter the disease, or com shock, or heart failure. List only co	ne cause on each line.	Do not enter the mode	of dying, such as card	diac or respiratory a	rrest,	Approximate Interval Between		
Physician/ Medical	Immediate Cause (Final disease or condition resulting in death)	a. Advanced Due to (or as a consequent	dement	ia Alehe	iner's	Type	Onset and Death		
Examiner	Sequentially list conditions,	b. ————							
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DRACO 0 1: be executed sician and 9: burial-transit	resulting in death) Last	Due to (or as a consequen	nce of):						
3760 fificate b g physi as the t	IF FEMALE:	d							
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Vital Vital hysician his certifi Il director	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	8/Outpatient 3 🗆 DO	26. Place of Death (C		dence 6 DOther (Spec			
ling Phy After thi uneral uneral	27. Manner of Death 1 Natural 5 □ Pending		Bb. Time of injury	Bc. Injury at work?		now injury occurred			
Division of tall or Attending P as after death is parter than the tall in by the funeration of the partificate:	2		M Me, farm, street, factory	1 Yes 2 No	28f. Location (S	Street and Number or Rui	al Route Number,		
Dir he Hospital of in 24 hours at he Funeral D poleted filled it		sician: To the best of my knowled	ge, death occured at	he time, date and plac	e, and due to the ca	ause(s) and manner as sta	ted.		
o the H ithin 24 o the F omplete	20h Signature and title of portifier	ner: On the basis of examination are Practioner: To the best of my kn	nowledge, death occur	red at the time, date and	place, and due to the	ne cause(s) and manner as	stated.		
F 3 F 5	Susenskher	~ CRNP	R	154032		4/11/201	1/		
5	30. Name and address of person who of SUSOW Schem C	ompleted cause of death (Item 23 RNP 800 So	Ba) (Type, Print) Wherly	Rd To	wson,	MD 210	286		
State Registrar	31. Date filed (Month, Day, Year) APR 1 2 2011	32. Registrar's Signature	New .		<u>`</u>				
DHMH 17 Rev 7/2009									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AMonth Physician/ 924 AM Raymond T. Carpenter Jr 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Feb 13, 1 X M 2 □ F Mary Tand Director 220-12-5141 86 1925 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 IISA 3407 Callaway Avenue 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc ģ 1 Never Married 2 X Married Maryland 21215-0036 hours after black 1 ☐ Yes 2 X No Specify: Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) teaching 12 educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence louise Myers permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic e Raymond T. Carpenter Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 3407 Callaway Avenue Baltimore, MD 21215 19a. Informant's Name/Relationship (Type, Print) Gloria Carpenter/spouse Baltimore, 20a. Method of Disposition 20b Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Renald S. Ward State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director Baltimore, MD Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause in each line. ediate Cause (Final Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician; The law requires that the death certificate be executed and -trans resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 1 Yes 2 9 Unknown 2 \square No has been signed by e e 2 should be detact 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate had funeral director, page 2 No 1 🗌 Yes Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 FR/Outpatient 3 IDOA မ After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? iniury 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier 🖒 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of portifier s of person who completed cause of death (Item 23a) 9/pe, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. N.2										11650	- April		
		1. Decedent's Name (First, Middle, Last) 2. Date of Death										3. Time of Death			
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Funeral	7.	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth									9. B	irthplac	e (State or Foreign	7	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State	10b. County				or Location						10d.	Inside City Limits	
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B L L		21. Signature of Fundal Service Licensee McCully-Polyniak Funeral Home P.A. 3204 Mountain Road Pasadena, Maryland 21122													
Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death													
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r sician: The law r s certificate has t lirector, page 2 sl	Completed	24a. Was an autopsy performed?									compl	etion of cause of			
ian: The stifficat ctor, po	Be C	25. Was case referre	ed to medical					26. PI	ace of Death (Check	1 Yes	2 4	o 1 □ Ye	es 2L	⊔ No	
Physic this ce	욘	1 Yes 2 2 27. Manner of Death		Hospital: 1 28a. Date of	patient 2 injury	ER/Out		DOA Othe	4 ☐ Nursing Ho				cify)		_
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or Atter de Virecto Virecto in by the	Sertif	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could r determi	ned 28e. Place of	Injury - At ho , etc. (Specif	1)	1	factory, office		28f. Location (S City or Tow		eet and Number or Rural Route Number, State)			
To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certific completed filled in by the funeral director,	Medical (29a. Certifier 1	Confifying	Physician: To the bes	t of my know	ledge, d	leath occu	ired at the time	, date and place, an	d due to the cau	use(s) ar	nd manner as s	tated		_
the Ho	Mec	only one) 3	☐ Certifying	xaminer: On the basis Nurse Practioner: To	of examinatio	n and/or y knowle	investigat edge, deatl	h occurred at the	e time, date and plac	e, and due to the	e cause(s) and manner a	s stated		æd.
6 ₩ 6 8		29b. Signature and t	title of certifier	100	Dep	44	1	29c. License				te signed (Mon	th, Day,	Year)	
101		30. Name and addre	ess of person w	vho completed cause	of death (Iten	1 23a) (T	ype, Print)		5 A			1 /	4	055	_
Stat		31. Date-filed (Month	h, Ray Year)	32. Red	is rar's Signa	ture.	D	69	> 0.1	mer	ıc	/T :	1		_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 1638 PM Anna R. Carman 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Sinai Horpital of Baltimore Baltimore n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/4/1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours 86 MD Director 212-20-6855 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exominat must be redlined at ™XYes 2 No Director MD n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3806 Dorchester Rd. 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1≹34'es 2 ☐ No 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: WWII Specify. þ Specify: White 3 Widowed 4XXDivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Retail Clerk Woolworth's 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be f and Mental I Thelma Murphy James Merritt Brinsfield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health a Important; if item 27 is any Injury or other trau once. 9508 Axehead Ct., Randallstown, MD 21133 James H. Carman/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Parial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 4/13/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, MD 21. Signature of Funeral Service Licensee ²²Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 s i. En or the disease, or complications that cause of e death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Immediate Gause (Final disease of condition resulting in death) **Physician** eroschio coronary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed certificate 2 1 No 2 No 1 ☐ Yes Vital r this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Division 5 Pending investigation To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and file of certifier D 53377 April 9,2011 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MAH A J.A.B.N. S. ALI, M.D. 2401 West Believed Ave, Beltimore, WD 21215 Day, Year) 31. Date filed (Month,

DHMH 17 Rev 1/2001

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 PerPHY G914 4/21/2011 JH
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ April Year 8,2011 Alma Conner Alma Connor 12:30A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford 1905 Shirley Avenue Joppa Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □ M 2 □XF Days Hours May 30, 1924 Director Maryland 213-20-1353 86 Usual Residence of Decedent items 23a or 28a-f show 10a. State injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 XNo Md Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1905 Shirley Avenue 21085 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mentai Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event the Natural. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify. 3
▼ Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Cafeteria Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eva G. Stricklin Robert C. Burton, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 1905 Shirley Avenue Joppa, Md. 21085 Denise Boyd 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 4-9-2011 Glen Burnie.Md. 21. Signature of Fundal Service Lie 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician STENOSIS HORTIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PERTENSION OYRJ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-trar Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as 1 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months
1 Yes 2 No Dav Year signed by the a g Unknown q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 **No** 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manne Medical Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending injury 2 Accident 3 Suicide M Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined 24 hours a Funeral L Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a of certific 29c. License number CARDIOLO GIST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RD. BELMR. MD21014 NAIR 602S. ATWOOD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 04 02^{Day} Physician/ 201^{ear} 11:45 P M Roosevelt Cleveland Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's 4705 Davis Avenue Suitland If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1**X** M 2 □ F Months 03/04/1933 Mary land Yrs Director 78 577-42-0714 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified Prince George's Suitland YYYes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20746 4705 Davis Avenue filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. by 1 Never Married 2 xMarried Yes 2X No Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates other than "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) DC Public Schools 10th School Bus Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o ၉ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ones. Page 1 and 2 should be i ment of Health and Menta Mary Elizabeth Brown Samuel E. Cleveland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donnette Y. Cleveland/Wife 20a. Method of Disposition 4705 Davis Avenue Suitland, MD 20746 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park04/09/2011 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home Signature of Puneral Service Licensee 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Congestive Heart Failure Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 2 years Ischemic Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a non-sequence cry ysician and e burial-tran Due to (or as a consequence of): Be Completed by Physician/Medical requires that the death certificate be the b Records, P.O. Box 68760 attending p for use as t If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Live 3 4 Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law autopsy After this certificate ha funeral director, page performed? XXX No 2 🗓 N 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 🙀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖺 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury 5 Pending 1 X Natural Accident Investigation n 24 hours after death e Funeral Director; A bleted filled in by the f 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor

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completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 04/05/2011 D0066377 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven K. Seigel 6041 Old Branch Avenue Temple Hills, MD 20748 31. Date filed (Month, Day, Year) APR 1 2 2011 32. Registras Signal State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:00 AM 01 Medical 4a. Facility Name (if not institution, give street and number or Location of Death 4c. County of Death **Examiner** holANO MOGE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day **Funeral** 9. Birthplace (State or Foreign Carolina Months Director items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Res 2 No 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Forces? White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes No Specify: If Yes, Give Year or Dates. 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry and Mental Hygiene. College (1-4 or 5+) Be Father's Name (First, Middle, Last) ဂ္ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked 19b. Mailing Address (Street and Number Method of Disposition 2 b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ZOII injury or Donation 5 Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between tAstatic Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 1 ☐ Yes 2 ☐ Unknown been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 Yes 2 No Yes 2 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 📝 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury work? 5 Pending 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARNER 10/IAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Va 2 : 29 PM tricia Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death HOSPICE BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birt **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🌠 F Months Davs Country) **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE MD1 Yes 2 □ No 10e. Street and Number ō 10a. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 2612 E. Biddle STREET 21213 u.s. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: BLACK 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Decement's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NFO SPECIAMST should be filed within 72! h and Mental Hygiene.
7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) NORTHROP GRUMMAN NFO Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Rebecca Rivels မ PUGH RANSON permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) haneild West DAUGHTER 2612 E. Biddle St. BALTO, MD. 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BALTIMORE, MD 04/16/2011 DNATIONAL Donation 5 Other (Specify) ignature of Funeral Service 22. Name and Address of Facility VAUGHN GREENE FUNERAL SOS P.A. 4905 YORK ROAD. BALTO, MD. 21212 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ue to (or as a consequence if) Ph_sician/ mid disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine ll any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or). the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ Pregnant at time of death Month Day Year 9 Unknown 9 Unknow Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ g 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 ANo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🗌 Yes 2 🔲 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventioning in an advantage of the course o 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier cense number 29d. Date signed (Month, Day, Year) 1100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W TOW SON MO 31. Date filed (Month, Day, Year 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 201 Year **Physician** 1:15 A M William J. Callis, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Broadnead Cockeysville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 5 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 95 218-07-4696 Director March Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mydical Eventher is nat the restlind at 1 ☐ Yes 2 👿 No Director Baltimore Cockeysville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13801 21030 U.S.A. York Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🛱 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Arbutus Memorial Cemetery President / Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be R. Callis Elizabeth Eisenhardt George ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tra once. 21111 Marjorie Fink / Daughter 16217 Corbett Village Lane Monkton, MD. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corporation 4/15/2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature of Funeral Service Licens 1050 York Road Towson, Martyland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and i be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>ک</u> 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 No 1 TYes 1 □Yes Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of Injury 28d. Describe how injury occurred After t 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date sidned (Mdnth. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ate filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARTIN COLAW APRIL 2011 LANE 11, 3:40 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GENESIS MULTI CARE TOWSON BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min. 1 □XM 2 □ F 10777774936 Director 229-30-9353 80 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits BALTIMORE TOWSON 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 305 E JOPPA ROAD 21286 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 X Divorced WWII Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SELF EMPLOYED RESTAURANT 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JONAS COLAW ETHEL WAYBRIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORENE MERENDA/SISTER 1302 WALKER AVENUE BALTIMORE, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State GARRISON PORESTO 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4/13/2011 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD CEMETERY 21. Signature of Funeral Service Licensee MOO217 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ CANCER UNG disease or condition erv. Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Alnerosder gronory has autopsy performed 20 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 3 No မ : After this c 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending n 24 hours after death.

le Funeral Director: Al oleted filled in by the fu 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 9650 Domb 31. Date filed (Month, Day, Year) 32. Registrar's Signature 21045 D State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Cente Baltimore Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕎 M 2 🗆 F Months Days Hours Min. Julinth, 21, Year 1946 Maryrand Yrs. 64 Director 218-46-5710 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a nr 9Rs. f char 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ler must be notified Bel Air Maryland Harford 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21014 903 Hack Berry Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【★No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) the Owner/Operator 12 Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Catherine Hoover Michael Joseph Christ Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Christ / Wife 903 Hack Berry Court, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify) Michael Luth. Cem: 04-11-11 Perry Hall, Maryland ature of Funera 21. Sig 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequent of): Examiner Secreptially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury consequence of signed by the attending physician and defached for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ should be 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I To the Hospital or Attending Physician: The lawithin 24 hours after death.

To the Funeral Director: After this certificate h performe Yes 2 No 2 🗆 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2 No ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in tiny opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur and (ittle of cert 29c. License number 29d. Date signed (Mgnth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi V. Datla 6701 N. CHARLES 51: Suite 5218, Towson, Maryland 21204 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month rabbe Alexander 1800 Medical Facility Name (if not institution, give street and number) County of Death **Examiner** 4b. City, Town, or Location of Death Howard County General Hospita alumbia 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 M 2 🗆 F Director Yrs. none Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits **Funeral Director** Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: "natural", 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha VA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Unknown and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a MOT 14ha 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, t, e cli Funeral Servius cense 22. Name and Address of Lacility slumba Part 1. First the disexte, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ prematuriti xtreme disease or condition resulting in death) Medical Due to (or as a consequence of Examiner 2000 Sequentially list conditions, Examine cause. Enter Underlying repture of membranes the burial-transif Cause (Disease or iinjury that initiated events cremature and ue to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 No After this certificate has been signed by the funeral director, page 2 should be detached g Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No 1 🗋 Yes 2 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No ၉ 1 🗌 Yes 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie D006240 Name and address of person who completed cause of death (Item 23a) (Type, Print) Holsey , 10710 Charter Drive 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Deborah Dixon	State of Maryland / Department of Health and Mental Hygiene	11660
	1- For State Certificate of Death Reg. No.	B B Trush Mark 1
Physician/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day April 9, 2011	3. Time of Death 1341 hrs
8	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital 4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birth (
Any	Usual Residence of Decedent 10a, State 100 Sounty 10c City, Town or Location	10d. Inside City Limits
suth with the Maryland items 23a or 28a-f show ast be notified at once. Inertal Director	10e. Street and Number 10f. Zip Code , 10g. Citizen of What Coun	1 Yes 2 No
ith the Martin the Martin or 23 nor 24 notified and Direct and Dir		can Indian Black
er death with , or items 23 r must be no		//
ours aft.	or Dates:	odustry
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Lant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Elementary/Secondary (0-12) College (14 or 5+) Child C	IGES
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical Traumatic event, the Medical Medical Complex of the	HARVEY DIYON, 1 DONZEII (114564)	4 4 0//
MD 21 d 2 should tht and Me n 27 is ma numatic or	19a. Informant's Name/Relationship (Type, Print) UBBANA) 19b. Mailing Address / Street and Number or Ryral Route Nymber, City of Territy 19b. Mailing Address / Street and Number or Ryral Route Nymber, City of Territy 19b.	Zip Chyd)/+/C/f/
Baltimore, MD semit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumant	20a. Method of Disp sit 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, page 20c. 2 cation 3 Qity in the company of other place) 4 Donation 5 Other Specify:	XXI, MO).
Balti permit. Departm Importa	2). Six nature of Fund all Service Licens 22. Name and Address of Facility 154	M.
Physician /Medical	23a. Part/I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
× <i>Ē</i> xaminer	Immediate Cause (Final disease or condition resulting in death) a. Primary pulmonary hypertension complicated by head injuries Due to (or as a consequence of):	
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	
, ce executed cician and irrial - transit dical Examine	events resulting in death) Last Due to (or as a consequence of):	
	☐ UNPENDED	
). Box 68760 the death certificate to the attending physiched for use as the burden Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	ay Year
P.O. Bc that the dearned by the aby	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to t	he cause of death?
s, P.C luires that n signed I Id be deta	Atherosclerotic Cardiovascular Disease; Myocardial hypertrophy: congestive heart failure: Diabetes Mellitus 1 Yes 2 No 3 Probi	
Division of Vital Records, P.O. Box 6876(Rospital or Attending Physician: The law requires that the death certificate femeral Director: After this certificate has been signed by the attending phyself filled in by the finneral director, page 2 should be detached for use as the ball Certification: To Be Completed by Physician/Me	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes	opsy findings available ompletion of cause of
ital Recipionician: The scentificate rector, page	25. Was case referred to medical 26. Place of Death (Check only one) examiner? [Hospital: 1 Institute: 2 ER/Outpatient: 3 DOA Others Murcine Home 5 Regidence 6 Others Others Murcine Home 5 Regidence 6 Others Oth	
of Vit ling Physic After this funeral dir	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
ion ttendin death. stor: A y the fu	1 Natural 5 Pending 1 Pending 1 Accident Investigation 1 Pending 1 Accident Investigation 1 Pending 1 Pend	
Division of Hospital or Attending Schours after death. Runeral Director: After filled in by the fun	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 22 S. Green Baltimore, Md.	al Route Number, City 1e St.
To the Fluorital within Shours I To the Fluorial Completely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.	
M P S P S	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon April 10, 2011	th, Day, Year)
1 be and	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State	Los Desires Grantes	
Registrar		
DHMH 17 Rev 1/2001 OCME 2006	OCME	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ethel Marie Date 2011 12:00 PM April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Baltimore Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Age (In yrs. last birthday) Month, Day, Year) February 13.1914 West Virginia Hours 1 □ M 2 🗶 F 532-24-3700 97 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 Dulaney Valley Rd. 21093 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 72 hours after 1 ☐ Yes 2 X No Specify: Completed Specify: white 3 X Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) 2121 Elementary/Seconday (0-12) 12 College (1-4 or 5+) homemaker own home Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Lee Hyatt Nancy Charlotte Gates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Date/son 8004 Sunnybrook Ct. Frederick, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem GardApr. 12,2011 Timonium, Maryland John O. Mitchell IV, Funeral Services of Dulaney Valley, 200 E. Padonia Rd. Timonium, MD 21093 P.A. 21. Signature of Funeral Service License 23a. Pag. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Carelo Vascolo Ilso Immediate Cause (Final Ph_sician/ disease or condition / Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events the burial-transi Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ETHEL certificate has autopsy performs 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: To 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work' s after death. 2 🗆 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 24 hours a Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I only one) 29b. Signature and title of APRIL 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 2300 DULANEY VALLEY ROAD TIMONIUM EDDIE NAKHUDA, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2.7 Day 20^{Ye ar} Physician March 5:09 Ρм Charles Edward Davis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Greenbelt 7730 Ora Ct. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days unk 1**X** M 2□ F Director 579-68-1725 60 Aug 17, 1950 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 27 is marked other than "natural", or items 23a or 28a-f shot traumatic event, it a five feath at 1 ☐ Yes 2 ☑ No Director MD Prince George's Greenbelt 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20770 USA 7730 Ora Court by Funeral death unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after unk 1 □Yes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No black. Specify: 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) unk permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, If a Marie once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be ٩ unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Price George's Police Dept 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 MOther (Specify) in state 21. Signature of Luneral Service Consee Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Failure **Physician** Kenal Chronic /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Exami burial-transi Diabeles Type II Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ed by the a detached f P.0. 1 □Yes 2 □ No 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 2 ► No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed After this certificate 1 ☐ Yes 2 - No 1 ☐ Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation ours after death.

leral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital e Funeral 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 2011 0006339

Registrar

State

7525 Greenway

Ctr Dr. Ste 105 Greenbelt, MD 20170

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Ahmedmo

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Leatha L. Davis 2. Date of Death 3. Time of Death Physician/ April 5, 2011 7:38 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince Georges . Social Security Number 577–50–5920 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 XF Months Days Hours Min. Decembers 1936Waskington, DC Director Usual Residence of Decedent 10a. State or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at , Town or Location Oxon Hill 10d. Inside City Limits Director Prince Georges 1 Yes 2 No 10f. Zip Code 20745 10g Sitizen of What Country? 10e. Street and Number Funeral 728 Audrey Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forcest

1 Yes 2 No Black, White, etc 1 Never Married 2 Married 3 Widowed 4 Divorced þ Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Escort / Federal Government Navy Yard 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 11th Be 18. Mother's Name (First, Middle, Maiden Surname)
Mary Green 7. Father's Name (First, Middle, Last)
David D. Hill ಲ 19a. Informant's Name/Relationship (Type, Print)
Albert Oscar Lomax / 19b, Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $5703\ Gloria\ Dr.\ Suitland\ MD$ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Nurial 2 Cremation 3 Removal from State Glenwood Cemetery 04/]4/20]] Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Dunn & Sons 5635 Eads St. NE Washington, DC 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Securationly list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death ☐ Yes 2 ☐ ☐ Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? this certificate has ral director, page 2: 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 400 ၉ 1 Inpatient 2 PR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 🗌 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Luther Charles Duvall pri1 1340 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Harford Air (In yrs. last birthday) 8. Date of Birth Funeral Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign November 24,1917 Maryland 213-12-4115 1 🛛 M 2 🗆 F Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director Abingdon Harford Md. · 28a-f 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20 Box Hill South Pkwy. USA 21009 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc.
White Armed Forces?

1 A Yes 2 No þ 1 Never Married 2 Married ò Maryland 21215-0036 1 Yes 2 No Specify: Year or Dates.1942-1945 "natural" 3 ★Widowed 4 □ Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Tastykake Salesman 8th Be permit. Page 1 and 2 should be filed. Department of Health and Mental Limportant: If item 27 is many injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Augusta L. Ritterhofer Charles Duvall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kingsville, Md. 21087 8025 Dowell Lane Step-Dtr. Gloria J. Williams 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 4-11-2011 Bel Air, Md. BelAir Memorial 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition OMMUN Medical resulting in death) Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No been signed by the 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has 1 Yes 2 100 Place of Death (Check only one) examiner? Hospital Other မြ 1 🗌 Yes 2 No 3 DOA Inpatient 2 - ER/Outpatient Division of Certificate: 27. Manne of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accide (Month, Day, Year) work?
1 \(\sum \) Yes 2 \(\sum \) No injury 5 Pending Accident Investigation 24 hours after death Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, it my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific cause of death (Item 23a) (Type, Print) 30. Name and address of person MA 31. Date filed (Moi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 5:15 рм ROBERTA DAVIS APRIL 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CATONSVILLE SUMMIT PARK HEALTH & REHAB CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Days (Month, Day, Year 09-29-1927 Months Hours Min 83 MARYLAND Director 215-30-6930 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE CATONSVILLE 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? r items 23a or iner must be n Funeral 1502 FREDERICK RD U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BLACK 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC 10th DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ PHILLIP HALL ROBERTA HUGHES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD DAVIS/SON 4779 BELWOOD GREEN, BALTIMORE, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) ZION CEMETERY 04-08-2011 BALTIMORE, MD a of Funeral Service Lig 22. Name and Address of Facility
WILLIAM C. BROWN COMMUNITY
1206 W. NORTH AVE. BALTO., FUNERAL HOME P.A. MD 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DEMENTIA Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner SENILI Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Examine Due to (or as a consequence of): HYPERIENSIN Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed 2 No NA 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) A TIENDING DE0 5 6 948 APRIL 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANSIND A 21218 BALTIMONE WILLIAM AVE

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 8, 2011 William Platt Duly, Jr. 12:26 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Dec. 7, Months Days Hours Min Maryland 70 1940 Director 216-40-1590 Usual Residence of Decedent 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral United States 21061 407 3rd Ave., S.E. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces?

1 XYes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Defense Wireman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mildred Zimmerman William Platt Duly, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 407 3rd Ave., S.W., Glen Burnie, MD 21061 Kathryn Duly / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 2011 12, cemetery, crematory or other place, 1 D Burial 2 X Cremation 3 D Removal from State Metro Crematory, Inc Catonsville, Maryland 5 Other (Specify) 4 🗀 onation Sen Name and Address of Facility rkley-Ruddick Funeral Home, P.A. I Crain Hwy., S.E., Glen Burnie, 21. Signat ideLicens MD 21061 0 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Disc to for asia consol terms of cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t page 2 s autopsy perform certificate 1 ☐ Yes 2 ☑ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medica Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 1105

Registrar

√ DHMH 17 Rev 7/2009

State

completed cause of death (Item 23a) (Type, Print)

Registrar's Si

21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ April1 Eldon Walter Dau 7:20 a M 10 Medical 4a. Facility Name (if not institution, give street and number, City, Town, or Location of Death ESSEX Examiner 4c. County of Death Riverview Rehab & Health Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 8. Date of Birth Days 1 🗙 M 2 🗆 F Months Hours Feb 25. 1926 85 Ilimois 218-26-7493 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director notified 1 🗆 Yes 2 🕇 No MD Baltimore Essex 0 10e. Street and Numbe 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral U.S.A. 1813 Old Eastern Avenue #225 21221 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗆 No If Yes, Give 1 44 – 1 46 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iter I Examiner ı Black, White, etc þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Supervisor 12 should be filed wit alth and Mental Hygie 27 is marked other or traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname)
Boness Be 17. Father's Name (First, Middle, Last) ဂ္ Walter Dau 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st.
Department of Health an.
Important: If item 27 is n.
any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8518 A Westerman Circle, Nottingham, MD 21236 William G. Dau-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Holly Hill 4/14/11 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Leonard J. Ruck 5305 Harford Rd., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) sclero Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if uny, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a do, sequence of, signed by the attending physician and deedeched for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day Pregnant at time of death Month Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' Director: After this certificate Yes 2 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 2 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my animals due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who comple ed cause of death (Item 23a) (Type, Print) 32. Registrar's Sig State Registrar

ORIGINAL

N DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:00pm M 2011 April **EUBANKS** ALICE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Ft. Washington fUnder 1 Year | If Under 24 Hrs. Ft. Washington Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🖾 F DĆ 577-46-7813 July 21, 76 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Evar aimer rust be cottined at 1 ☐ Yes 2 No Director MD Prince Georges Temple Hills 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20748 USA 2203 Oak Tree Lane Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 1 ∐Yes 2⊠ No Specify. Specify: δ 3 ☐ Widowed 4 ☐ Divorced Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DC Government 4 yrs. marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental H Gustava Brokenburr James L. Eubanks ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 any injury or other tronce. Temple Hills, MD. 20748 Fred B. Eubanks - Husband 2203 Oak Tree Lane Baltimore. 20c Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 XBurial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 4-11-2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Tuneral Service Licensee Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respirto Physician UNKNOWAL disease or condition resulting in death) /Medical Due to (or as a consequence 1) Examiner ERMINA MULTIPLE UNKKOWY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed ronboay burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown signed by be detail 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by tutor 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown WITH 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? yes 2 No certificate 2 □No 1 SION 1 Yes Hospital or Attending Physician: within 24 hours a er death.

To the Funeral Director: After this certific completely filled in by the f. neral director, 25. Was case reference examiner? medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 0 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JO U

Registrar

DHMH 17 Rev 1/2001

State

Ft. Washington, MD 20744

11711 Livingston Rd.

32. Registrar's Signaty

30. Name and address of per on the completed cause of death (Item 23a) (Type, Print)

J. Kleiman, MD

2011

Samue1

31. Date filed (Month, Day, APR 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Raymond Arthur E	1	on St For State	ate of Maryla		oartme <i>ertifica</i>			l Mental H		Reg. No.	011	1669
Physician	1	. Decedent's Name (First, Midd	le,Last)		•				2. Date of De Month	Day	Year	3. Time of Death
Medical Examine			thur East			The second			April 3, 2	2011		1828 hrs
		 Facility Name (if not institution 7869 Leymar Road 	n, give street and nu	mber)		41	. City, Town, or L Glen Burnie	ocation or Deat	n		nty of Death Arundel	
Funeral		Social Security Number	6. Sex	7. Age (In yrs	s. last birth	iday)	If Under 1 Year	If Under 24Hr	s. 8. Date of E	Birth (MM/DD/Y	YYY) 9. Birth	place (State or
Director		213-82-6450	1XM 2F	39		Yrs.	Months Days	Hours Mir	Tuno	2, 1971	Foreign Cour	ntryMaryland
	ŀ	Jsual Residence of Decedent	1601111 2011	33	,	110.			Journe	2, 17/1		rial y land
any	1	0a. State 10b. County		10c. C	ity, Town o	r Locatio	n					10d, Inside City Limits
and show	5 N	Maryland Anne	Arunde1	G1	en Bu	ırnie						1 Yes 2 No
Maryli 28a-f d at o	130	0e. Street and Number				10f. Zip Code				10g. Citizen o	f What Count	ry?
or items 23a or 28a-f sho imust be notified at once	5	7869 Leymar Rd					21060			es		
th with	1	Marital Status X Never Married 2 Marr		edent Ever in prces?	U.S.	13. Was	Decedent of Hisp s, specify Cuban,	panic Origin? (S Mexican, Puerto	pecify Yes or No Rican, etc.)		Race - America Vhite, etc.	an Indian, Black,
or it	2		1 Yes	2 X No		4 🗆 ,	res 2 X No			Cana		
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	େ -	3 Widowed 4 Div	or Dates:		16a D		Usual Occupation		work done		of Business/In	
5-0036 cd within 72 hour lygiene. other than "natu		Elementary/Secondary (0-12)					st of working life.					
thin 7 than than than than		12			l Bi	uvin	g Agent			Food	d Indu	stry
21215-0036 uld be filed within 72 hours af Mental Hygiene. marked other than "natural cevent, the Medical Examin	3 7	7. Father's Name (First, Middle,	Last)					8.Mother's Nam	e (First, Middle			
De fil		Norman Alexa		on				June Es				
O & B 12 2		9a. Informant's Name/Relations			1		Address (Street					
2 = 1 = 1	_	Vanessa LaTona Oa. Method of Disposition	/ Sister			800	2nd St. on (Name of cem		ows Poi		2121 ion - City or T	
		1 Burial 2 X Cremation	n 3 Removal fr			ry or othe				250. 2500.	on ony or r	own, otato
Baltimor permit. Pages Department of Important: If injury or othe		4 Donation 5 Other S	oecify:	M	etro		atory		5/2011	Cator	nsville	e, Maryland
Ball Sermit Separt Impo	12	1. Sonator of Fx ral Service	Licensee			ZZ. Na	me and Address rkley-Ru l Crain	ddick F	unera1	Home,	P.A.	01061
Physician	1/2	3a. Fart I. Enter the disease, or	complications that c	aused the dea	ath. Do not	enter the	L Crain mode of dying, s	HWY . SE	GLen	rrest, shock, o	e, MD rheart	21061 Approximate Interval
Medical Examiner	;	failure. List only one cause mmediate Cause (Final disease or condition resulting in death)	on each line.	ne and	Etha							Between Onset and Death
ted nisit	ammer	Sequentially list conditions, frany, leading to immediate cause. Enter Underlying Cause Disease or injury that influeted events resulting in death). Last	Due to (or as a								4.00	
executed an and all - transit		Trend resulting in death, East	d									
be ex		X UNPENDED				-f p	er me g9	14 4–15	-11 vt	Lood Day		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the building Certification: To Be Completed by Divisional Man	2 SICIALIVE	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unit	ne 1 Live b	ant at time of	2	=	I death 3	Ectopic pregn	ancy	Mont	te of delivery th Da	ay Year
that the d		Part II. Other significant condit	ions contributing to	death but no	t resulting	in the un	derlying cause gi	ven in Part I.	23e. Did	tobacco use c	ontribute to th	ne cause of death?
Division of Vital Records, P.O. rat or Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detachartification: To Be Completed by E									1 🗌 Y	es 2 No	3 Proba	ıbly 4 🗹 Unknown
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ital Recions: The certificate rector, page		5. Was case referred to medica	IS.				26.Place	of Death (Check	-	2 110	1 🗸 100	2
f Vital Physician or this certi		examiner? 1 ✓ Yes 2 No	Hospital: 1	npatient 2	ER/Ou	tpatient	3 ☐ DOA	Other Nursi	ng Home 5	Residence	6 🗸 Other:	Scene
ding Ph		7. Manner of Death	28a. Date	of Injury , Day,Year)	28b. T	ime of Inj	ury 28c. Injury	at Work?	28d. Describe	e how injury oc	curred	
ion tending or: 4		1 Natural 5 Pend 2 Accident Inves	Carl III and III	-3-11	fd	6:25	pm 1 Ye	es 2 🗶 No	unknow	n		
Division pital or Atten ours after death teral Director filled in by the	<u> </u>	3 Suicide 6 X Coul	00 01	e of Injury - A	t home, far	m, street	factory, office bu	ilding, etc.	28f. Location	(Street and No State) 786	umber or Rura	al Route Number, City
Division o spital or Attending tours after death. neral Director: After filled in by the fune	5	4 Homicide	rmined (Specify)	fo	und a	t ho	me		Glen B	urnie,	Md.	
To the Hospi within 24 hos To the Funct completely fil			hysician: To the bes	of examination								
To ron	Ž Z	9b. Signature and title of certifie	and manner s	tated.			29c. License	number		29d. Date	signed (Mont	th, Day, Year)
		the !!	. too	O e.			O.C.M	1.E.		April 4,	2011	
1 V	-	0. Name and address of person	who completed caus	se of death (It	em 23a)							
peru		Patricia Aronica-Polla		ant Medica			111 Penn Str	eet, Baltimo	re, MD 212	01		
Stat Registra	te ³	1. Date filed (Month Doy, Your)	11 Seren	gistrar's Sign	ature	Red						
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Donna Lynn Eber Apr 6, 2011 8:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery **Casey House** Social Security Number 8. Date of Birth (Month, Day, 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Months Hours Country) 212-76-3549 46 May 2, 1964 MD Director Vrs Usual Residence of Decedent 28a-f shor aţ 10a, State 10b. County Howard death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD Garrell Woodbine 1 🗆 Yes 2 🛮 No 0 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country's 23a Funeral 15839 Bellis Dr. 21797 U.S.A items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 9 þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced Specify: Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Senior Patient Trainer Home Medical Therapy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ **Leonard Brandt Jones** Elizabeth Louise Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Jones mother 9441 Farewell Dr. Columbia, MD other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or Apr 09, 2011 Glen Burnie, MD **Atlantic Crematory, LLC** 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 once. any Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failude. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MOVIC Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Por 5 Other (specify) Month Pregnant at time of death Day Year should be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy yes 2 V No 1 Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗆 Yes 2 V No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manor of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Curtifying Nurse Prantioner: To the best of my his wildges death produced at the time, date and place and due to the name(s) and manner stated. unly one) the 29b. Signature and title of cer 29c. License numbe ည 29d. Date signed (Month, Day, Year) D37142 Name and address f person who completed cause of death (Item 23a) (Type, Print) CCOrd 32. Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Mar 26, 2011 Year Christopher G. Flynn 20:56 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery <u> Montgomery General Hospital</u> If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth **Funeral** Social Security Number Age (In vrs. last birthday) Days (Month, Day, July 26, 1**XX** M 2 □ F Hours Min. 54 112-52-6264 Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shounty injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director Montgomery 01 nev 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20832 4105 Sir walter Rd 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Specify: White Completed 3 Widowed 4xx Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Credit Union Mortgage Broker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gloria Lawrence Joseph A. Flynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 81 Bancroft Ave., Staton Island, NY 10306 Dierdre Flynn 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗱 Burial 2 🗌 Cremation 3 👺 Removal from State April 2, 2011 Staton Isl, NY 10309 Resurrection Cemetery 4 Donation 5 Other (Specify Fink Sian 22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061 M01148 Gregory 23a. Part 1. Enter the diseas shock, ox beart failure. omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between ore cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) a Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No signed by the a d be detached for 4 ☐ Pregnant 9 ☐ Unknown 1 Li Yes 2 L 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 1 1 16 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital 1 Impatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation after deatt Director: 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Prectioner. To the best of my knowledge of ell produced at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Phillip Dr., Olney, MD 20832 31. Date filed (Month) State Registrar

/DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:20p.M 04 2011 Medical name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Edgewood Road Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Min. 1 □ M 2 🔀 F Director 217-30-5103 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Baltimore 1X Yes 2 ☐ No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 4001 Edgewood Road Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces 1 X Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Black 3 Divorced 4 Divorced and Mental Hygiene.
Is marked other than "naturanmatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School 3yrs Secretary 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Helen Epps George Jasper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4001 Edgewood Road, Baltimore, Md 21215 Iris Joyner-Sister Health tem 27 permit. Page 1 and 2 Department of Health Important: If item 2 any njury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 4/9/2011 On-Site Baltimore, Signature of Funeral Service L March F/H West 4300 Wabash Av Ave, Baltimore, Md 21215 and 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Scar fally let an officer if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician be detached for use as the burial Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify)
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical funeral director. 26. Place of Death (Check only one, Other: 2 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Sid ature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD21201 DRAL 0001 31. Date filed (Month, Day, Year) State Registrar

FREELAND, DORIS

		State of Maryland / Department of Health and Mental Hygiene
		Registrar Certificate of Death Reg. No.
Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year APRIL 6 2011 10:06 AM
Medic Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		Sinai Hospital of Baltimore Baltimore City 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year 1 If Under 24 Hrs. 8. Date of Birth 9. Birtholace (State or Foreign)
Funeral Director		5. Social Security Number 215-30-9245 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign (Month, Day, Year) Country) 9. Birthplace (State or Foreign (Month, Day, Year) Sept. 10 1933
d d	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
larylan 3a-fsh ified a	Director	MD NA Baltimore 1X yes 2 □ No
the M a or 28 be not	I Dir	10e. Street and Number 2802 Mosher Street 10f. Zip Code 21216 10g. Citizen of What Country?
th with ms 23: must	Funeral	USA
nore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1
5-00 hours	olete	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
121 thin 72 ane. than "	Completed	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired)
d 2	വി	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
ylan d be fi Mental arked	입	London Brooks Glennie Knox
, Maryland 21215-0036 add 2 should be filed within 72 hours after salth and Mental Hygiene. n 27 is marked other than "natural", of er traumatic event, the Medical Exami		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 N. Gorman Ave. Baltimore, MD 21223
altimore, rmit. Page 1 and partment of Hea portant: If item y injury or other ce.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
ting treet transfant		4 Donation 5 Other (Specify) Arbutus Memorial Pk. 4/13/2011 Arbutus, MD 21. Squattre of Funeral Service Licensee 22. Name and Address of Facility 4200 Fine are Asserting
Bal permi Depar Impor any ir		22. Name and Address of Facility 4300 Wabash Avenue March Funeral Home West Baltimore, MD 21215
		23a. Part 1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart valure. List only one cause on each line. Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death Onset and Death
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xecute	Exar	Cause (Disease or linjury that initiated events resulting in death) Last c. Attered Mental Status Due to (or as a consequence of):
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687 ertifica ding p	/Me	IF FEMALE: 23b Mas decedent program 23c. If yes, outcome of pregnancy
Box 687 death certifics he attending p led for use as t	Physician/Me	In the past 12 months? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 No 4 Pregnant at time of death 5 Other (specify) Month Day Year
P.O. Bo	Phys	9 Unknown 9 Unknown
ords, P.(l by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown
prds requir	letec	Attrial Fibrillation 24a. Was an autopsy findings available prior to completion of cause of
Recc he law te has age 2 s	Completed by	Arabetu Mellitus Type 2. autopsy performed? death? 1 Yes 2 No 1 Yes 2 No
of Vital Rec Physician: The laver this certificate has	Be C	25. Was case referred to medical examiner? 26. Place of Death (Check only one)
f Vij	욘	1 Yes 2 No
on of nding Phath.: After the funeral	icate	27. Manper of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 28d. Describe how injur
Division of Vital Records, pital or Attending Physician: The law requires ours after death. eral Director: After this certificate has been sig filled in by the funeral director, page 2 should b	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Medical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To t To t		29b. Signature and title of certifier Chaudhary (MBBS) 29c. License number 29d. Date signed (Month, Day, Year)
6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TYOTI CHAUDHARY, MBBS SINAI HOSPITAL OF BALTIMORE
Stat Registra	e	31. Date filed (Month, Day, Year) 32. Pignstar's Signature
DHMH 17 Ray 7/20		APR 12 2011 Seven S. Jacks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ $2\overset{\mathrm{Year}}{0}\overset{\mathrm{1}}{1}$ April George Fullam 12:40A M Kenneth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u>Union Hospital</u> of Elkton Elkton Cecil Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Days Min New York (Month, Day, Year) 05/03/1926 Director 84 126-16-7495 Usual Residence of Decedent Director 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 28a-f 1 X Yes 2 No MD Cecil Rising Sun or 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 457 Telegraph Road 21911 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after to Department of Heath and Mental Hyghen. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Lisual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Grinder Operator Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fullam Caroline Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Pearsall / Daughter Telegraph Road, Rising Sun, MD 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🔀 Donation 5 🗌 Other (Specify) Anatomy Gifts Registry 04/11/2011 | Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Fineral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ my occurd we faction Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? Hypertemi 24a. Was an autopsy Diates meeter 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Propatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury work? 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 223 Next main St MD 31. Date filed (Month, Day, Year) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HQ Hook Physician/ Frases 0451 Medical 4c. County of Death **Examiner** General HOSPIta Howard Columbia 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 4Min. (Month, Day, Year) Apr 9, 2011 Country) 0 MD Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director MD Columbia Howard 1 Yes 2 No 10e, Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Funeral 23a 21045 6691 Possum Ct. U.S.A. items 2 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. "natural", or 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 SKAN If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Specify: Completed Jamai the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. infant infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mark Anthony Rico Fraser Etica Yong Snyder should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .92 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Erica Fraser mother 6691 Possum Ct. Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 5 Apr 13, 2011 Clarksville, Maryland Columbia Memorial Park injury 4 Donation 5 Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 ature of Funeral Service License any 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of) resulting in death) Last the burialphysician Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Yes 2 No been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 04 00 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No Records, 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of death? has page 2 2 No certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 🗆 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury Certificate: Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No М Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death examination. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) MD Lane 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#1perpHYS, G914, 4/12/2011 WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Frances L. Gallagher 2. Date of Death Physician/ April 20 T GALLAGITOR, FLANCES L. 11:45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1811 Franwall Ave. Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** May 27, 1945 Hours 1 🗆 M 2 💢 F Months West Virginia 577-62-3868 65 Yrs **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 72 hours after death with the Maryland the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 X No Montgomery Silver Spring 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral items 23a 1811 Franwall Ave. 20902 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc ō þ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates "natural", Completed Specify: 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Computer Service and Mental Hygie is marked other Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Donald. Frank Ormsby permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic sonce. Katherine Anna Shepler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Gallagher / Husband 1811 Franwall Ave., Silver Spring, MD 20902 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2X Cremation 3 \square Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 04/08/2011 Beltsville, MD 21. Signature of Funeral Service Licensee M6038Z Rapp Tuneral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ END SHOGE RENal disease years disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Melleons DIABERES years Coqueritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anyotrophic lateral Schoolis Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 1 No certificate I of Vital the Hospital or Attending Physician: 25. Was case referred to medical B B 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \blacksquare Residence 6 \square Other (Specify) 1 ☐ Yes 2 🛣 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide d in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical 1 Medical Examiner: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) Hecks, M.D. 019192 April 5, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3941 FERRALA DRIVE WHEATON, MD 20906 BARREL HECEN, 40 31. Date filed (Month, Day, Year) **APR 1 2 2011** 32. Registrar's Signature State

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Registrar

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P.O. Box 68760 Records, Hospital or Attending Physician: T 24 hours after death. Funeral Director: After this certifics Division of Vital the

28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d. Date signed (Month, Day, April 11, 2011

within 24 hours after

To the Funeral Directory to the Funeral Directory to the Funeral Directory to the filled in b

Medical

only one)

29b. Signature and title of certifier

homas Masterson MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Masterson, M.D. 6858 Old Dominion Dr. #104 McLean, Virginia 22101

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day April 2011 6:50 AMM George William Greaver, 11 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Russell Frost Court Essex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Social Security Number 7. Age (In vrs. last birthdav) Year) 1952 1**X** M 2 □ F Months Days Hours Min. Maryland Director June 218-58-3517 58 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if filem 27 is marked other than "natural", or items ??? any injury or other traumatic event. the ***. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 1 Russell Frost Court S. Α. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1972 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced 1973 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Welder Steel Fabricator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ George William Greaver. Elsie Anders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell Frost Court Baltimore, Maryland 21221 Susan Bernadette Greaver (Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. Middle River, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdziński Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cirrhosis Medical Due to (or as a consequence of): Examiner Alcoholic Liver Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or) that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X page 2 Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) မ 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 2 No Accident Investigation 24 hours after deal Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License numbe 4/11/2011 H0055992

Registrar
DHMH 17 Rev 7/2009

State

6730 Holabird Avenue Baltimore, MD 21222

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Gallo,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month Mary Elizabeth Gordon 10:15 April 11 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 X F 214 40 3810 68 **Director** Sept. 24, 1942 Maryland Usual Residence of Decedent Show or 28a-f shov notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Cecil Conowingo 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a or Funeral 21918 121 Leona Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No | V | 10 (UM) | Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Dispatcher Cab Company and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Lawrence Schaech 1 and 2 should be of Health and Menta Annie Laurie Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Gordon (Son) 121 Leona Drive Conowingo, Maryland 21918 27 other Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4/15/2011 Bayview Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Tre Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. nterval Between Onset and Death Physician! disease or condition Medical resulting in death) Due to (or a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events -tran and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 month Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by onyopathu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate 2 L No 1 ☐ Yes 2 ☐ No Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? _2 🗹 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 1 L Natural 5 Pending 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie er Chisapeake Dr. Bel Air, MD 21014 pleted cause of death (Item 23a) (Type, Print) 500 U 32. Registrar's Signature State APR 12 Registrar DHMH 17 Rev 7/2009

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Physici Medical Exam		1. Decedent's Name (e (First, Middle,Last) if not institution, give			City, Town, or Location	2. Date of D Month March 3	eath Day Year 31, 2011 4c. County of Deat	
Funeral Director		5. Social Security N	1540 10	7. Age (In yrs.	last birthday)	Under 1 Year If Under 1 Year If Under 1 Year If Under 1 House Ho		Anne Arundel Birth (MM/DD/YYYY) 9. Bir	thplace (State or
yland e-f show any lonce.	tor	Usual Residence of 10a. State 10e. Street and Nu	10b. County	10c. City	Town or Location	f. Zip Code		10g. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No
ath with the Mar tems 23a or 28s st be notified a	Funeral Director	11. Marital Status 1 Never Marri	EUDEN	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was De	2///4 ecedent of Hispanic (Origin? (Specify Yes or ean, Puerto Rican, etc.)	U.S.A	ican Indian, Black,
2 hours after de: "natural", or i	þ	3 Widowed	4 Divorced ducation (Specify only	1 Yes 2 No f Yes, Give Year or Dates: v highest grade completed) College (1-4 pr 5+)	16a. Decedent's U	No speci sual Occupation (Gir f working life, DO No	ve kind of work done	Specify: B/	ACK Industry
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Intelligent If Hiera 27 is marked other than "matural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Be Completed	17. Father's Name	(First, Middle, Uast)	N-A ES		T8 Moti	ner's Name (First, Middle	B. Maiden Surname	HINS
re, MD 21 1 and 2 should FHealth and Me If item 27 is ma	To	20a. Method of Dis		100 KINS	19b. Mailing Ad	DRUGEN (Name e ery,	lumber or Rural/Rodde	lumber, City or Town, State	Zip Code) ///4 State
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traum		4 Donation 5		. IV	"AH N	and Address Fac	-17-7-11 13-121 14-121 AVE	OF ALLES N	TANOL NEGATION
Physician /Medical xaminer			ly one cause on eacl Final disease a	ations that caused the death n line. Sudden unexpl ue to (or as a consequence of	ained dea			arrest, shock, or heart	Approximate Interval Between Onset and Death
	aminer	Sequentially list co if any, leading to in cause. Enter Under (Disease or injury to events resulting in	nmediate Di ndying Cause hat initiated c.	ue to (or as a consequence o					
lox 68760, leath certificate be executed e attending physician and for use as the burial - transi	ledical Ex	☑ UNPENDED	d	AMENDED 23a, 27,		16,6-6-11	sm	23d. Date of deliven	
Box 68760, e death certificate be the attending physic of for use as the but	Physician/Medical	23b. Was decedent past 12 months		Live birth Pregnant at time of de Unknown	2 Fetal d	eath 3 Ecto	pic pregnancy		y Day Year
Cords, P.O. Bot law requires that the de- has been signed by the . 2 should be detached fi	ē	Part II. Other signi	ficant conditions o	ontributing to death but not r	resulting in the under	lying cause given in		tobacco use contribute to Yes 2 No 3 Protesta	
tal Recordician: The law ro	Be Completed	25. Was case refer					th (Check only one)	formed? death? s 2 No 1 ✓ Ye	
of Vi ing Physi After this	유	examiner? 1 ✓ Yes 27. Manner of Deatt 1 X Natural 2 Accident	2 No	28a. Date of Injury (Month, Day, Year)	ER/Outpatient 3 28b. Time of Injury		ork? 28d. Describ	Residence 6 Other	
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the i	al Certification:	3 Suicide 4 Homicide 29a. Certifier	6 Could not be determined Certifying Physician	(Specify) To the best of my knowled	lge, death occurred	at the time, date and	or Town	use(s) and manner as state	ed.
To the J within 2 To the J complet	Medical	one) 2 2	Medical Examiner: 0 atitle of certifier	on the basis of examination a nd manner stated.	and/or investigation,	n my opinion, death	occurred at the time, da	te and place, and due to th	e cause(s)
	- 1	(al	ce 1x	ellan	petron.	O.C.M.E.		April 1, 2011	

DHMH 17 Rev 1/2001 OCME 2006

State 31. Date filed,(Month, Day, Year). Registrar

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

1168

			For State Registrar	State of Mary		e <i>rtificate of l</i>			gierie Reg. No.	
			Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath	3. Time of Death
	Physicia Medic		Lelia Ha	rt				Month 04	11 201	1 8:00 P ^M
	Examin		4a. Facility Name (if not institution, give			4b. City, Town, o	r Location of Death		4c. County of Dea	ath
-			1910 Frederick Ro				nsville I If Under 24 Hrs.	1	Baltimo	
	Funeral Director			D 82 -	yrs. last birthday 35 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da) 10–13–	v. Year) C	rthplace (State or Foreign ountry) TTALY
	and show at	٥	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits
	Maryla 18a-f	Director	Maryland Baltimo	re	Cat	onsville				1 ☐ Yes 2X No
	a or 2 be no	Ö	10e. Street and Number		041	10f. Zip Code			10g. Citizen of What C	ountry?
	h with	Funeral	1910 Frederick Ro	ad			1228		USZ	<i>A</i>
Maryland 21215-0036	e flied within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 ☐ Never Married 2 1 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puert			ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: V	
15-0	72 hou n "natı Aedica	nplet	15. Decedent's Ed (Specify only highest gra	de completed)	(Gi	cedent's Usual Occup re kind of work done o DO NOT use retired)	during most of wor	king	16b. Kind of Business	s Industry
212	led within Hygiene. other thar ent, the N	e Col	Elementary/Seconday (0-12) 10th grade	College (1-4 or 5+)		ctrical M		ing	Electro	onics
and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Francesco No.	9			18. Mother's Nan Maria		Maiden Surname)	
ary	1 and 2 should be f f Health and Menta item 27 is marked other traumatic ev		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Ma	ailing Address (Street	and Number or Rui	ral Route Number	r, City or Town, State, Z	(ip Code)
	and 2 s Health s em 27 i		Joseph Hart / HUS	BAND	191	0 Frederi	ck Road,	Catonsv	ille, MD 21	228
Baltimore,	je 1 and t of Hea If item or other		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State		position (Name of rematory or other plac	ce)	Date	20c. Location - City of	r Town, State
Ħ	permit. Page 1 Department of Important: If i any injury or once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Specific			ematory II				e, Maryland
Ba	Depar Depar Impol any ir		21 Signature of Juneral Service Licens	om ins	n	299 Frede	erick Roa	d. Balt	imore. Mary	Maryland INC
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	olications that caused the	death. Do not e	nter the mode of dyir	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
	Physician/) Medical		Immediate Cause (Final disease or condition resulting in death)	a Parki	450y	Dise				Onset and Death
June	Examiner			Due to (or as a co	insequence of):					
	sit d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):					
B	xecute n and al-trans	Exar	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of):					
09/	cate be executed physician and s the burial-transit	ledical		d						
9289	, = 50	Med	IF FEMALE:							
Box 6	ath ce attend for use	cian/	in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnand	ру		23d. Date of d	elivery Day Year
O. B	the de by the ached	Physician/M	1 ☐ Yes 2 No g ☐ Unknown	g 🗌 Unknown						
, P.O.	requires that the death certifical been signed by the attending p should be detached for use as	by	Part II. Other significant conditions co	entributing to death but n	ot resulting in the	e underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death? Probably 4 Unknown
ords	been should	letec						24a. Was a		utopsy findings available
Rec	sician: The law certificate has rector, page 2	Completed						autop	osy prior to rmed? death?	completion of cause of
ta	cian: ertifica ector, I	Be (25. Was case referred to medical examiner?	Janaitati			ace of Death (Chec			
f Vi	Physic this c al dire	욘	1 Yes 2 No 27. Manner of Death	lospital: 1 Inpatient 28a, Date of injury	2 ER/Outpat		4 ☐ Nursing H		lence 6 Other (Spe	cify)
o uc	nding l ath. r: After ie funer	icate	1 Natural 5 ☐ Pending AccidentInvestigation	(Month, Day, Ye		work		28d. Describe h	ow injury occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S		street, factory, office		28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check Medical Examin	ician: To the best of my ner: On the basis of exam e Practioner: To the best	ination and/or inv	estigation, in my opinio	on, death occurred a	at the time, date a	nd place, and due to the	cause(s) and manner stated.
	To the within To the comp.	2	29b. Signature and title of certifier		. or my knowledge	29c. Licenso	number		29d. Date signed (Mon	
	6		1	- W.D	•	Dec	7128-	7	4/12/11	
	2		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type	Print) C S	+.(+	0 410	5 Balt	nele 404
	Stat Registra		31. Date filed (Month, Day, Year)	32. Negistrar's	Signatur	faces	,	1	6	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 04-05-2011 1020 A Edward Carroll Harmon, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 X M 2 🗆 F 05 MOT to Day 926 **Director** 84 220-22-9865 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2505 Fairway Drive 21015 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

X Yes 2 \(\sum \) No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Superintendent Animal Control Be permit. Page 1 and 2 should be filed be Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward C. Harmon Sr Martha Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia E. Harmon (Wife) 2505 Fairway Drive Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bel Air Mem. Gardens 04-08-2011 Bel Air, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signat p of Fuyer 610 W. MacPhail Rd BelAir, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical Medical Examiner resulting in death) Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ☐ Yes ∠∟ ☐ Unknown been signed by the should be detached Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performe 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 No 1 🗌 Yes ျှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manper of Death 28b. Time of Certificate: 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation after death Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a, Certifie 🗬 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated **Qertifying Nurse Practioner**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu 29c. License numb 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 500 UPPER CHESAPEAKE DRIVE BEI RINA WIKITYANSKAYAMO

Registrar
DHMH 17 Rev 7/2009

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL STANLEY IWANCIO Year 1251 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MERCY CITY BALTIMORE BALTIMORE 5. Social Security Number 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign County) Aryland 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Months August 16, 1943 212-42-9165 67 Yrs **Director** Usual Residence of Decedent or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Md. Baltimore City 1X Yes 2 □ No 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be ı 250 S. President Street USA Suite 706 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 $\overline{\chi}$ Yes 2 \square No If Yes, Give 1961 – 1967 1 \square Yes 2 $\overline{\chi}$ No Specify. Year or Dates. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", White Completed 3 Divorced 4 Divorced Specify: the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Techincian Telephone Company permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Sibiski Stanley M. Iwancio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 250 S. President Street Suite 706 Balto. Md.21202 Elizabeth K. Iwancio Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Holy Rosary 4-11-2011 Balto. MD. 4 Donation 5 Other (Specify) Schimunek Funeral Home 22. Name and Address of Facility 9705 Belair Road 21236 Nottingham, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ oronar disease or condition resulting in death) Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No ☐ Live Birth ∠ ☐ Fregnant at time of death☐ Unknown Month Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? within 24 hours after death.

To the Funeral Director: After this certificate ompleted filled in by the funeral director, pag 1 Yes 2 5 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 \sum Yes Other: 2 No 잍 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred 'Matural 5 Pending work? 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗆 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD P24459 2011 APRIL ss of person who completed cause of death (Item 23a) (Type, Print) ALMALKX YAZIID 301 St. Paul Street Balto.Md. 31. Date filed (Month, Day, Year, 32. Registras Sign State 2 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10^{ay} 201^{Year} April Kene M. Jacobs a^{M} 10:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Morningside House Ellicott City Howard Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. (Month, Day, Yea 05/25/193 Director 77 505-34-7038 Nebraska Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he mattered at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 ☐ Yes 2 🛂 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4525 Cornflower Court 21043 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 → Widowed 4 □ Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Rundell Sylvia Kricsfeld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Jacobs - daughter 4525 Cornflower Court Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State St. Johns Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/13/ 2011 Ellicott City, Md. Signature of Funeval Service Lic 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Cardio Vascular Dipease Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 🗌 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 1) 30641 Name and address of person who completed cause of death (Item 23a) (Type, Paint).

Ramely Sakapathi 201-109 Back River Neck Road Esser Maryland 21221 31. Date filed (Month, Day, State 2 Registrar

DHMH 17 Rev 7/2009

11-02640

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adage Jacques	State of Maryland / Depart	rtment of Health and Mental H ificate of Death	lygiene 20	11685
Physician/ ledical Examine	1. Decedent's Name (First, Middle, Last)	modic of Dodin	Reg. No. 2 Date of Death Month Day Year April 6, 2011	3. Time of Death 1727 hrs
	4a. Facility Name (if not institution, give street and number) Howard County General Hospital ICU	4b. City, Town, or Location of Death Columbia		h
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 216 21 9043 1 M 2 F 36	st birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	1Forei	
faryland 28a-f show any 1at once. ector	MD Howard	Fown or Location Columbia		10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once al Director	4	10f. Zip Code 21046	10g. Citizen of What Co. Haiti	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at sonce To Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc. Specify: Bla	rican Indian, Black,
5-0036 led within 72 hours e Hygiene. other than "natura the Medical Exami Completed b		16a. Decedent's Usual Occupation (Give kind of oduring most of working life. DO NOT use reting the Disabled.	work done ired) 16b. Kind of Business	/Industry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	17. Father's Name (First, Middle, Last) Rodrique Toussaint	18.Mother's Name	(First, Middle, Maiden Surname) ne Jacques	
Baltimore, MD 21215-00; permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med To Be Comp	19a. Informant's Name/Relationship (Type, Print) Gustane Levasseur - mother 20a. Method of Disposition 20b. Pi	19b. Mailing Address (Street and Number or I 8962 Skywalk Court ace of Disposition (Name of cemetery,		46
Baltimore, permit. Pages 1 ar Department of Her Important: If ite Important:	1 X Burial 2 Cremation 3 Removal from State	ematory or other place)	6-2011 Ellicot	t City, MD
Balt Departs Importing Information	23a. Part I. Enter the disease, or complications that caused the death. I	4112 Old Columbia Do not enter the mode of dying, such as cardiac of	Pike Ellicott City or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions a. Gardiac Arrhyt Due to (or as a consequence of): b. Gardiac Hypert		by Pneumonia	Death
and transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
<u>Z</u> a - Z	■ UNPENDED	,per me,g91/ 7-25-11 s 6,6/28/2011,WS 23a-b,per	me,g922 12-29-11 sr	
Records, P.O. Box 68760, The law requires that the death certificate be tate has been signed by the attending physicipage 2 should be detached for use as the burn:completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of deat 1 Yes 2 No 9 V Unknown 9 Unknown		Day Year	
s, P.O. It inters that the signed by the detached by the detached by the detached by the detached by Ph	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	bably 4 🗹 Unknown
of Vital Records, and Physiciae: The law require where the law require when the this certificate has been signeral director, page 2 should be not To Be Completed				utopsy findings available completion of cause of es 2 No
f Vital Physiciaes r this certi ral director To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Injury 2 ✓ E	26.Place of Death (Check R/Outpatient 3 DOA Other Mursin 28b. Time of Injury 28c. Injury at Work?	only one) g Home 5 Residence 6 Othe 28d. Describe how injury occurred	r
ion troods the fi	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No	28f. Location (Street and Number or Re or Town, State)	ıral Route Number, City
	4 Homicide determined (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and		due to the cause(s) and manner as stal	
To the He within 24 To the Fu To the Fu Complete!	29b. Signature and title of certifier Our beway	29c. License number O.C.M.E.	29d. Date signed (Mc	
State		111 Penn Street, Baltimore, MD 212	01	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Marril 4 Day 2011 Year Physician/ 3:10 PMM William Kuhns Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death E1kton Cecil. Elkton Care & Rehab 5. Social Security Number unk 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth APT 129, Year) 937 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Days 1 X M 2 D F Pennsylvania **Director** 73 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Markla Hygiene. Important: If item 27 is markled than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Cecil E1kton MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21921 101 W. Main Street 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{N} \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify 3 Divorced 4 X Divorced Completed Year or Dates unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) custodial unk unk Be unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Stoney Chase Drive Elkton, MD 21921 Belinda Moore/friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🔀 Other (Specify) in state Signature of Fineral Service 32 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Raltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, be heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) ifficile Colitis **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying and I-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day ☐ Pregnant at time of death ☐ Unknown the 9 Unknown Division of Vital Records, P.O. ģ signed to d be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Rev hatreme 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy HTN certificate | Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 🗷 No 1 Tes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) **Director:** After this of in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending iniury work? 2 🗌 No Investigation M Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by determined City or Town, State) within 24 hours a To the Funeral D

State Registrar

Medical

29a. Certifier

(Check 29b. Signature and title

of certifier

SHAHNAWAZ

MD

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0062190

2533 AUGUSTINE HERMAN HUY, SUITEA, CHESAPEAKE CIT

29d. Date signed (Month, Day, Year)

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Caroline Kaufmann 11:00 a^M 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2508 Parkview Road Woodlawn Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. 88 Months Days Hours 01/26/1923 1 □ M 2 🕱 F Yrs. Director 215-18-7282 PA Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Woodlawn MD Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Iral", or items 23a o Funeral 2508 Parkview Road 21207 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural" 3 X Widowed 4 Divorced Specify. Completed White the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Medical Secretary Medical other traumatic event, æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H မ Charles E. Russell permit. Page 1 and 2 should be Department of Health and Menl Important: If item 27 is marker any injury or other traumatic. Lucy Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2508 Parkview Road Woodlawn, Karen Brown - daughter MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 04/12/2011 4 Donation 5 Other (Specify) Ardent Crematory Hanover, MD Signature of Fundal Servi 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Discore Immediate Cause (Final Physician/ disease or condition wonic Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown Dav Year Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has certificate 2 H10 Yes Yes 25. Was case referred to pedica funeral director, 8 26. Place of Death (Check only one) examiner? living Other: Certificate: To 1 🗌 Yes 2 No 1 🗌 Inpatient 2 🗀 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending injury hours after death. 1 Tes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 0 3 0 6 4 1 April 11 2011 0 laun Name and address of person who completed cause of death (Item 23a) (Type Print)

amesh Sabapathy 201-109 Back Ruw meck Road Bathmane Maryland

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ STEPHANTE KURDYS APRIL 2011 P.M 3:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1604 DEER MEADOW COURT HANOVER ANNE ARUNDEL Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ 🔀 Days Hours Min 61 ITALY **Director** 216-52-5868 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No HANOVER MD ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21076 1604 DEER MEADOW COURT 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ş 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ϊ No Specify: If Yes, Give Year or Dates Specify: WHITE "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) 2 YEARS HOMEMAKER OWN HOME of Health and Mental Hygie f item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ GIUSEPPA DI STEFANO permit. Page 1 and 2 should be f Department of Health and Menta LORENZO NOTO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1604 DEER MEADOW COURT 21076 HANOVER, MD MARTIN P. KRUDYS/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of DULANEY PARTY OF THE P 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once, X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 4/14/2011 COCKEYSVILLE, MD **GARDENS** THE JOHNSON FUNERAL HOME, P.A. Signature of Funeral Service Licensee 22. Name and Address of Facility MO0217 8521 LOCH RAVEN BLVD. TOWSON. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death REAS Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner cuantially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ig physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy this certificate 2 **N**No 1 ☐ Yes 2 ☐ No Yes Division of Vital 24 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No Matural Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar DR

32. Registrar's Signature

KNOU

31. Date filed (Month, Day, Year,

			Flease	State of Manua					•	·.
			For State	State of Maryla		artment of r tificate of L			2011	11689
	_	_	Registrar 1. Decedent's Name (First, Middle, Las:	*)	Cel	unicate of L	Jeani ————————————————————————————————————	2. Date of Deat	eg. No. U	11000
	Physicia Medic	al	<u> </u>	Robert	Knoec			Month 4	- 9 - 11 Year	3. Time of Death
7	Examir	er	4a. Facility Name (if not institution, give:	PICE AT the	Lake	Sali	SOURI		4c. County of Dea	mico
	Funeral Director		5. Social Security Number 294-16-3860 6. Se Usual Residence of Decedent		s. last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 04/1 6/	1922 ^{9. B}	irthplace (State or Foreign ountry) OH
	Maryland 8a-f show tified at	rector	10a. State MD Worces	ter 10c.	City, Town or Lo	cation Be	rlin			10d. Inside City Limits 1 ☐ X Yes 2 ☐ No
	s 23a or 2 uust be no	Funeral Director	10e. Street and Number 24 Moonra	ker Road	-	10f. Zip Code	21811	1	0g. Citizen of What C	USA
9000	s filed within 72 hours after death with the Maryland tal Hygiene. ed other then "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Air Year or Dates.	,	Was Decedent of H f Yes, specify Cuba	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	
Maryland 21215-0036	led within 72 ho Hygiene other then "nat ent, the Medica	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Seconday (0-12)		(Give	dent's Usual Occup kind of work done o O NOT use retired) ACCOUN	during most of work	ing	16b. Kind of Business	s Industry
/land 2	ould be filed worken that and the mar ed othe maticevent,	To Be	17. Father's Name (First, Middle, Last) Charles Kno	echel			18. Mother's Nam Anna	e (First, Middle, N	flaiden Surname)	
, Mary	č ⊆ 10 ⊃		19a. Informant's Name/Relationship (Ty) Norma Ferrese		n 315				City or Town, State, Z sboro, D	
Baltimore,	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Fi		sition (Name of natory or other plac THEY CREM	e) 4/12	Date 2/2011	20c. Location - City o Woodbine	
Bal	permit Depar Impor any in		21. Signature of Funeral Service License	Dorota Mars	hall 22	. Name and Addres Ma PO	ss of Facility Aryland Box 14	Cremat:	ion Servi ltimore,	ices MD 21203
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_	icate be executed g physician and is the burial-transit	cal Examiner	Cause (Disease or impury that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
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. Box 6876(To the Hospital or Attending Physician; The law requires that the death certificate within 24 brouz after death. with a 24 brouz after death. completed filled in by the funeral director, page 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ For 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	elivery Day Year
ls, P.O.	uires that th n signed by ıld be detac	ا ۾	Part II. Other significant conditions co	ntributing to death but not r	resulting in the u	nderlying cause giv	en in Part I.		acco use contribute t	o the cause of death? Probably 4 D Unknown
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\geq	Physic this co	유	T LI fes Z LIFINO	ospital:			4 ☐ Nursing Ho	me 5 Reside	nce 6 Other (Spe	cify)
o c	Jing F	ate	27. Mann∍ of Death 1 ≧ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	?	28d. Describe hov	w injury occurred	
Division of Vital Records,	al or Attences after death	Certificate:	2 Accident 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec			Yes 2□No	28f. Location (Str. City or Town,	eet and Number or Ru State)	ural Route Number,
_	he Hospita in 24 hours he Funeral ipleted fille	Medical	(Check 2 Medical Examin	cian: To the best of my knoer: On the basis of examinat Practioner: To the best of	tion and/or invest	igation, in my opinio	n, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
	Veith Coal		29b. Signature and title of certifier	ents		29c, License	number (75/5	29	Od. Date signed (Mont	h, Day, Year)
	11x,		30. Name and address of person who co	YAMA 9	110 BA	rint) STERN S	HORE)	Ny SALI	ISBURY M	11021804
	Stat Registra	_	31. Date filed (Month, Day, Year)	32. Registrar's Sig	auture auto					, , , , , ,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 7, 2011 1:35 P. M Virginia Kemp Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Potomac Arden Courts Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Unknown Months (Month, Day, Year) March 6, 1917 1 🗆 M 2 🔀 F Days Hours **Director** 246-09-7179 94 Usual Residence of Decedent 28a-f show 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Montgomery Bethesda 1 Tes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 20817 8805 Honeybee Lane United States and 2 should be filed within 72 hours after death Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Government/Military Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked 2 Noah P. Kemp Anna McNees 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Cynthia L. Keith/Niece 8805 Honeybee Lane, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Maplewood Cemetery Burial 2 Cremation 3 Removal from State April 13, 4 Donation 5 Other (Specify) 2011 Durham, North Carolina 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Sethesda-Chevy, Chaseac Inc. 7557 Wisconsin Avenue Bethesda-Chevy Chase Inc. M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death weeks Physician/ disease or condition resulting in death) Hip Fracture Medical Due to (or as a consequence of) **Examiner** Unsteady Gait vears Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence Cause (Disease or linjury that initiated events resulting in death) Last mp Due to (or as a consequence of physician Physician/Medical 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months? Month Day Year 1 Yes 2 No ed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed lirector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, Diabetes mold 1 \square Yes 2 \bigcirc No 3 \square Probably 4 \square Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 V N the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes 4 Nursing Home 5 Residence 6 Nother (Specify) Other: <u>_</u> 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of al or Attending Poster death.

I Director: After the 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred ☐ Naturaí 5 Pending work? 1 ☐ Yes 2 😿 No 2 X Accident March 17, 2011 JZOOM Investigation 6 Could not be Fell on Level Ground 3 Suicide 4 Homicide To the Hospital or Atter within 24 hours after ded To the Funeral Director completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) 10718 Potomac Tennis Ln. Potomac, Maryland determined Assisted Living Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D34590 April 8, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy E. Fried, M.D. 7758 Wisconsin Avenue, #211, Bethesda, Maryland 20814

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 2 2011

32. Registrar's Signature

11-02714 Laurren Kulski

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 O I I

		1- For State Registrar			Certific	ate of	Death			R	leg. No.			
Physician		Decedent's Name (First, Midd)	e,Last)						2	. Date of Dea	ath			3. Time of Death
Medical Examin		Laurren Kulski								Month April 9, 20	Day 011	Year		0548 hrs
		4a. Facility Name (if not institution	n, give street and n	umber)		41	b. City, Town, o	r Location				County o	f Death	
		Baltimore Washingtor	Medical Cente	er			Glen Burni				lΑ	nne Aru	ındel	
Funeral	4	5. Social Security Number	6. Sex		yrs. last bir	thday)	If Under 1 Ye	ar If In	der 24Hrs.	8 Date of Ri	rth /8484/I	200000	a Rint	nplace (State or
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it is it is	8	Bruce E. Kulski						Jean	Marie	Sylvia				
21215-0036 Mental Hygievier Markel Hygievier market other than "natural", c event, the Medical Examiner		19a. Informant's Name/Relations	hip (Type, Print)		19	b. Mailing /	Address (Stre				nber, Cit	y or Town	State,	Zip Code)
MD 21215-0036 and 2 should be filed within 7 latt and Mental Hygiene. m 27 is marked other than 8 wumatic event, the Medica		Bruce E. Kulski	Fath	er	1	10 Kin	qs Way Di	r Ba	Itimore	. MD 21	226			
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. The file of the f	t	20a. Method of Disposition			20b. Place	of Dispositi	on (Name of ce			Date		ocation -	City or 1	Town, State
of H		1 Burial 2 XX remation	3 Removal fi	rom State		ory or othe	. ,		A 11	2011	D-1		MD	
Pag ment or o	L	4 Donation 5 Other Sc	ecify:		Bayvie					, 2011	Dan	timore	, mu	
Baltimore, MD 21215-G permit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the 1	- 13	21 Signature of Funeral Service	Lidensee			22. Na	me and Addres	rat Fasili	Me, P.	١.				
E 5 7 3 E		K. Gregory Frink	M0114	8		4	26 Crain	Hwy S	., Gler	Burnie	, MD	21061		
Physician	1	23a. Part I. Enter the disease, or failure. List only one sause	complications that c	aused the	death. Do no	t enter the	mode of dying	, such as	cardiac or re	espiratory arr	est, sho	ck, or hear	rt	Approximate Interval
/Medical		Immediate Cause (Final disease					c Fibro		arutoi	педату	MIL	.11		Between Onset and Death
£xaminer		or condition resulting in death)	Due to (or as a			arura	C FIDIC	212						
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S87		3b. Was decedent pregnant in the past 12 months?	e 1 Live b	pirth	2	Feta	I death 3	Ectop	ic pregnanc	y	40.4	Month	Da	ay Year
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the death cert by the attendir	≝L	1 Yes 2 No 9 ✔ Unk	a Clikik											
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ath.	<u> </u>	1 X Natural 5 Pendi	ing	, Day, rear,			1 🗆	Yes 2] No					
isior Attender death rector:	3		tigation 28e. Plac	e of Injury -	At home, fa	rm, street,	factory, office t	ouildina. e	tc. 28	f. Location (S	Street an	d Number	or Rura	al Route Number, City
Division of Vital Records, P.O. spital or Attending Physician: The law requires that it tours after death, acral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact Contributed by B.		deter	not be (Specify)	, ,				Ů.		or Town, S				
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2	• ²	29b. Signature and title of certifier	1 /	Sun .			29c. Licens							h, Day, Year)
		Millen B	1011011.11	(4)			O.C.	M.E.			April	9, 2011		
Oknd	3	30. Name and address of person	who completed caus	se of death	(Item 23a)									· · · · · · · · · · · · · · · · · · ·
Soperd		Melissa Brassell, MD	Assistant Me			111 Pe	nn Street, E	Baltimor	e, MD 21	201				
Stat	e 3	31. Date filed (Month, Day, Year)	32. Re	strar's Si	gnature &	190								
Registra		APR 1	2 2011 2	know	1 1.	1994	-							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRI 2011 9:20A.M Yvonne Longerbeam Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Reeders Memorial Home Roonshoro 8. Date of Birth (Month, Day, May 19, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 X F West Virginia 19<u>36</u> Director May 218-30-9557 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 X No MD Washington Sharpsburg 10f. Zip Code 10g. Citizen of What Country? Funeral 21782 USA 6112 River Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 Married ☐ Yes 2 💢 No Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates : If item 27 is marked other than "nature or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Restuarant Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cleo J. Grimes Heywood Longerbeam 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shoul Department of Health and Important: If item 27 is m any Injury or other traum: once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6112 River Road Sharpsburg, MD 21782 Hope Cooper/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 04/13/2011 Woodbine, MD Signature of Funeral Service License 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Me Reverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury for use as the burial-tran that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate has page 2 1 Yes 2 No Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pending Investigation Accident 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie сопретер (Check within 2. only one 29b. Signature and title of cert 29d. Date signed (Month. Day, Year) 0063233 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 580 NORTHERN AVENUE, HAGERSTOWN, MARYLAND 21742 301-733-4496 SHAHID MAHMOOD,

State Registrar 31. Date filed (Month, Day, Yea APR 12

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Joseph Hugo Lopez Physician/ 0444 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not Institution, give street and number) 4c. County of Death **Examiner** NICOMICO SALISHIRY TENINSULA REGIONAL 8. Date of Birth (Month, Day, Year) Feb. 16,1941 If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Davs Min. Months Hours 1 🗐 M 2 🗆 F Philippines Director 70 547-60-8875 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy pinty or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Pittsville MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 21850 35154 Betty Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 XYes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Filipino Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) A T & T 12 Years Electronic Fabrication Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fermina Hugo Jose Lopez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35154 Betty Court Pittsville, MD Mrs. Joan M. Lopez (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4/8/2011 Hilltop Service Corp. Towson, Maryland 4 Donation 5 Other (Specify) Signature of Fundal Service Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner sequentially list comments, if any, leading to himsedate cause. Enter Underlying Cause (Disease or linjury Due to for as a consection of on nding physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 20 1 Tyes 25. Was case referred to predical Be 26. Place of Death (Check only one) Hospital Other: 1 Tyes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation the Suicide 6 Could not be within 24 hours after de
To the Funeral Directo
completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) IENNIS M.D. 100 E. CARROIT 31. Date filed (Month, Da 32. Registrary Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Dacedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0700 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Security Number Age (In yrs. last birthday) Hours (Month, Day, Year) an. 17,1922 1 XM 2 - F Min. 185-14-3312 Jan. Yrs. Pennsylvania **Director** 89 Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 28a-f 1 Yes 2X No MD Baltimore Edgemere 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 7230 River Drive Road 21219 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. , or Completed by 1 Never Married 2 Married 1 XYes If Yes, Give 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3₺ Widowed 4 □ Divorced Year or Dates. WWII White is marked other than "natur aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Crain Operator Steel Industry 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Liberetta Duronio Gialorenzo Leone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important. If item 27 is any injury or other trau once. 7230 River Dr. Road Edgemere, Maryland Lawrence Anthony Leone 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗵 Burial 2 🗌 Cremation 3 🗆 Removal from State Oak Lawn Cemetery 4/11/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign up of Funeral Service Linesee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ ardiomyopathy disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) burial-trar CENTIFICATION APPROVED BY Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical **Hospital or Attending Physician:** The law requires that the death certificate be eath hours after death. Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown ☐ Yes 2 ☐ No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Completed by hip fracture 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 Tyes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. examiner? 1 X Yes Other: 2 | No မှ 1 XInpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide work? 1 🗆 Yes 2 💢 No 5 Pending after death. Director: Aft 3|29|20|1 UnKnown 1 | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined Home 17230 River Drive Rd, Edgemere MD 21219 Medical 🖹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F nly one 29c. License number D0069441 4-7-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roven Boulevard, Baltimore MD 21218 3900 Loch State Registrar

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If w Illudical Environment be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - State Registrar		,	(Cer	tificate of l	Death			Reg. No	ZUI	No. of California	11595
	1. Decedent's Name (First, Middle, La	ast)							2. Date of Dea			Vaar	3. Time of Death
ian	Albert Peck Li	.ttle							April	9,	2	$\overset{Year}{0}\overset{ar}{1}$	12:35 P ^M
cal ner	4a. Facility Name (If not institution, gir	ve street and number,			Т	4b. City, Town, or	r Location	of Death		4c	. County	of Death	
	16425 Equestrian	Lane				Derwoo	od				Mon	tgome	erv
			je (In yrs. I	ast birth	day)	If Under 1 Year	If Unde	r 24 Hrs.	8. Date of Birt	th (T	9. Birthp	lace (State or Foreign
	408-30-2075	1 X M 2□ F	89	Yr	s.	Months Days	Hours	Min.	(Month, Da Septembe			Nort	h Carolina
1	Usual Residence of Decedent		10c. City	Town	×1.00	ation						1/	0d. Inside City Limits
=	10a. State 10b. County		Toc. City	, rown c	or Loc	alion						1,0	1 ☐ Yes 2 ☒ No
ecto	Maryland Montgom	ery	Dei	CWOO	<u>d</u>	1 m = 0 m				10.0	/ 344		
Funeral Director	10e. Street and Number	T				10f. Zip Code 20855				-	tizen of W		•
eral	16425 Equestrian		Francis III		40 W			-1-1-2 (0	aif . Van au Na		.ted		
Š	11. Marital Status	12. Was Decedent Armed Forces?		D.	lf. V	as Decedent of H Yes, specify Cuba	an, Mexica	an, Puerto I	Rican, etc.)	-		K, White, e	an Indian, etc.
	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑Yes 2 ☐ If Yes, Give Year or Dates:	LILITT		1	□Yes 2🌠 No	Specify	<i>/</i> :			Specify:	Whi	te
Completed by	15. Decedent's E	ducation	""11	16a. D	eced	ent's Usual Occup	ation			16b. K	and of Bus		
ple	(Specify only highest grant Elementary/Secondary (0-12)	rade completed) College (1-4or l	5+)	(0	Give k life. D	ind of work done o O NOT use retired	during mo d)	st of workii	ng				
Ö		4	.,	Adm	ini	strator				NA	SA		
Be (17. Father's Name (First, Middle, Last	t)					18. Moth	ner's Name	(First, Middle,	Maider	Surname	9)	
၉	Malcom G. Little	<u> </u>					Mar	garet	te Pec	k _			
	19a. Informant's Name/Relationship	(Type. Print)		19b. N	/lailing	Address (Street	and Numi	ber or Rura	l Route Numb	er, City	or Town,	State, Zip	Code)
	Julia Cunningham	ı / Daughte	er	16	425	Equestr	cian	Lane	Derwo	od,	MD	2085	5
	20a. Method of Disposition	78	20b. P	ace of Demetery,	ispos <i>crem</i>	ition (Name of atory or other plac	e) ;	April D	ate	20c. L	ocation - (City or To	wn, State
	1 ☐ Burial 2 ሺ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other <i>(Speci</i>		1			rematorium	, I		2011	Bet	hesd	a, Ma	aryland
	21. Signature of Funeral Service Lice	nsee			22. Rob	Name and Addresert A. Pum	ss of Faci	lity Funera	1 Home/R	locky	 	Tnc.	
	10-306 2		M01	596	300	W. Montgo	mery	Avenue	Rockvi	lle,	MD'	20850	
	23a. Part 1. Enter the disease, or com shock, or heart failure. List only	nplications that cause	the death	. Do no	t ente	r the mode of dyin	ng, such a	s cardiac o	r respiratory a	rrest,		!	Approximate Interval Between
	Immediate Cause (Final disease or condition	a. Cardia	e Am	rost									Onset and Death
	resulting in death)	Due to (or as											
١.	Sequentially list conditions	_{b.} Vascul	ar D	isea	se							1.	5 years
inei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of)	:								
E E	Cause (Disease or injury that initiated events resulting in death) Last	С											
l û	resulting in death, Last	Due to (or as	a consequ	ence of)	:								
Medical Examiner		_ d											
	IF FEMALE:	000 16									E AVE		
ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death		Ectopic pregnanc	у				23d. Date Mor	e of delive nth	ery Day Year
sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant a 9 □ Unknown	it time of d	eath	5⊔	Other (specify) _							
P	Part II. Other significant conditions	contributing to death t	ut not resu	lting in tl	he und	derlying cause give	en in Part	I.	23e. Did t	obacco	use contr	ibute to th	ne cause of death?
Completed by Physician/	Chronic Renal	Insuffici	ency						1 🗆 ነ	Yes 2	⊠ No	3 ☐ Prob	pably 4 ☐ Unknown
ete									24a Was	an.	l oah v	Vore outo	ney findings available
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ပိ	05 11/2								1 □ Yes	2 X N) 1	□Yes	2 No
Be	25. Was case referred to medical examiner? 1 🏋 Yes 2 □ No	Hospital:				3□ DOA Othe	or:		(Check only o				
<u>ان</u>	27. Manner of Death	1 ☐ Inpati		28b. Tin		3 L DOA	4 🗆 1		ne 5 🔀 Resi				y)
tion	1 X Natural 5 ☐ Pending	(Month, De	y, Year)	Inju		28c. Injur Work	رې Yes 2∐		.og. Describe i	iow inju	ny occurr	Ju	
fica	3 ☐ Suicide 6 ☐ Could not b		l urv - At ho	me. farm	n. stre		-	-	28f. Location (Street a	nd Numbe	er or Rura	al Route Number,
erti	4 ☐ Homicide determined	28e. Place of Inj building, et	c. (Specify)	,	, ,, -			City or To				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
alc	29a. Certifier 1X Certifying P	hysician: To the best	of my know	wledge,	death	occurred at the tir	me, date a	and place,	and due to the	cause(s) and ma	anner as s	stated.
Medical Certification: To		miner: On the basis of and manner st	of examinat										
Me	29b. Signature and title of certifier	140.	2	1	\	29c. License	e number			29d. Da	ate signed	Month,	Day, Year)
	Kolma	-11 (DX	en	M	۷	D2355	6			Apri	1 11	, 20	11
4	30. Name and address of person who		,	, , ,		*							
	Robert H. Blee,					Avenue,	#14	00 0	Chevy C	hase	e, MD	20	815
ite	31. DaPR (Mon2 2017ar)	22. Regist	ar's Sign	ure	y								
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Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) /onth 16:38 PM **Physician** 20 William R Meyers Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** HOS 110 6+ 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) Social Security Number **Funeral** Days Hours Min. $\overset{\text{Year})}{1964}$ Months 1 → M 2 □ F Maryland 46 216-94-6965 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Director Hanover Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21076 USA 1764 Simms Lane Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 🖾 Married White If Yes, Give Year or Dates: 1∐Yes 2∭XNo Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced I Hygiene. other than "natural", Completed WINCOM INCOMBAILIMOILE, Maryland 21215-0 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Fire Prevention 12 Sprinkler Fitter s 1 and 2 should be filed with Health and Mental Hygien item 27 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Ann Troche William R Meyers Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health a
Important: If item 27 is
any Injury or other trau Barbara A. Meyers-Mother Simms Lane Hanover Maryland 21076 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Park |Apr.13,2011| Elkridge Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sundroma **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and I-trar Due to (or as a consequence of) burial-Records, P.O. Box 68760, attending physician Physician/Medical ₽ ‡ as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy lor I Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed certificate 1 🗆 Yes 2 No Division of Vital e Hospital or Attending Physician: 1 24 hours after death. e Funeral Director: After this certifica Be Was case referred to medical examiner? 26 Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 <u>₩</u>No 2 ER/Outpatient 3 DOA Certification: To 1∐ Yes 1 Inpatient funeral 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 27. Manne of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) nd title of certifier 29b. Signatur 2ES-000

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Mo

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ath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. Middle Name (First. Last 2. Date of Death 3. Time of Death Physician/ April 1:22 PM 2011 Medical Examiner Location of Death 4c. County of Death N/AIf Under 1 Year 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days (Month, Day, Year) OV. 4, 1948 Months Min. 1 😿 M 2 🗆 F Hours West Virginia 196-38-9913 62 Director Nov. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Mass. Centerville Barnstable 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 Long Pond Circle 02632 United States or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces Black, White, etc. Yes 2 X No Completed by 1 Never Married 2 😾 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft.
Department of Health and Mendat Hyglen.
Important. If item 27 is marked other than "natural",
any injury or other traumatic event, the Medical Exai If Yes. Give 1 ☐ Yes 2 🙀 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chief Investment Officer Prudential Financial 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Arthur Joseph MacBride Jane Haberkorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 565 West End Ave., Apt. 2B, New York, NY 10024 Melissa MacBride / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 s 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 04/11/2011 Baltimore, Maryland Signature of Funeral Service Licensee Alvson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lige ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the bunal-trans that initiated events Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ex-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsy performed?

Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Deal 28b Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending wor 1 Tyes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 🖼 Certifying Nurse Practioner: To the best of my knowledge, death or ocurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29d. Date signed (Month, Dav. Year) 201 who completed cause of death (Item 23a) (Type, Print 20 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ 10 2011 3:36 Carole Joan McCleary Рм Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4600 Coleherne Road Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 2) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 M 2 XF **T**939 Pennsylvania 71 218-36-6114 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 4600 Coleherne Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Specify: 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Social Security Elementary/Seconday (0-12) College (1-4 or 5+) Administration File Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Ritchie Blanche Kosmal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leila McCleary / Daughter 316 Westshire Road, Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 04/11/2011 Baltimore, Maryland Taylor Signature of Funeral Service Licensee Alvson K 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician} disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami burial-transit Due to (or as a consequence of) physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 m Month Day Year Pregnant at time of death Unknown signed by the a No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗌 No 3 Probably 4 - Unknown Completed To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been signompleted filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No Yes 25. Was case referred to medical Be examiner? 2VZ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 Other (Specify 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one 29b. Signature License numbe 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar , Dày, Yea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** iam 10:17 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Somerford Place Annapolis If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 89 456-28-6952 Director Oklahoma Mar 9, 1922 Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Modeal Expulper most be notified at 1 TyrYes 2 □ No Director MD Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20715 USA 12511 Brewster Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after Affiled Folces: 1XTYes 2 ☐ No If Yes, Give Year or Dates:1942–46 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within the and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental William Eldridge Miller, Sr. Kate Jameson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Helen Miller/wife 14997 Health Center Dr. #157 Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Woodbine, Maryland Final Journey Crematory 04/12/2011 21. Signature of Funeral Service License 22. Name and Address of Facility
Coing Home Cremation Service P.O. Box 784
MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) accident Cerebrovascular Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a conse wence of Due to (or as a consequence of): P.O. Box 68760, attending physician certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, <u>م</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has certificate 1 ☐ Yes 2 🗹 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Mann of Death ne Hospital or Attending Pin 24 hours after death. 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29d. Date signed (*Month, Day, Year*) 4 - 11 - 201/ 1)50725 MD Erans Hwy Millersville, MD 21108

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death immediate

years

years

1 Yes 2 X No

11:50 A M

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

William D. Parnes 18109 Prince Philip Dr. Suite 225 Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month P M 2011 Edward Basil McAllister Apri] 4:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Nov 28, 1925 1 🛛 M 2 □ F Months Hours Min. Maryland Director 85 <u>579-24-7857</u> Usual Residence of Decedent ishow 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 🔀 Yes 2 🗌 No Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Examiner must be Funeral items 23a 5109 Hampden Lane 20814 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. ō 1 Never Married 2 Married þ 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White "natural", 3 Divorced 4 Divorced Completed Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Certified Public Accountant Private Business Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Basil Foster McAllister Sarah Gouldman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Page 1 and 2 Tania McAllister / Wife 3620 Littledale Rd. Kensington, MD 20895 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Journey Crematory 4/12/2011 Woodbine, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Coing Home Cremation Service P.O. Box Beverly L. Heckrotte, P.A. Clarksville MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of): **Examiner** End Stage Cardiomyopathy Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury for use as the burial-transi Severe Mitral Regurgitation that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Congestive Heart Failure IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a detached f 1 ☐ Yes ∠ ∟ 9 ☐ Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy perform 1 ☐ Yes 2 🔀 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 XNo To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral dir မှ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D\$\$68167 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sdmir 3600 Old GEORGETOWN Rd

DHMH 17 Rev 7/2009

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2011 **Physician** April 11, ANDREE BAER MOLLING 11:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death N/A 3900 North Charles Street, *#*717 Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 💢 F July 3, 1917 Switzerland Director 217-44-3727 93 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 3900 North Charles Street, #717 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status iled within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White <u>م</u> 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 French Teacher Private School and Mental Hygies s marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thibaud Helene Arthur Baer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 sl vartment of Health ar vortant: If Item 27 is r injury or other trau 702 Fairway Drive, Towson, Maryland 21286 (Son) Christopher P. Molling Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Important: It any injury o Green Mount Crematory 4/12/2011 | Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 21. Sign and Funcial Service Users Burn MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ovarian concer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Division or Vital Records, P.O. Box 687600 Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached for ☐Yes 2XNo 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 o Hospital 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident or Attendate after death filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30 Name and

31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

mD

32. Registrar's Signature

5505 HUPLANS

ddress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 17:30 **Physician** MARCH JOHN MYER 201 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 19, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 1933 **Funeral** Days Hours Min 1 ▼ M 2 □ F Maryland 212-30-4121 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ahow the Medical Examiner must be notified at 1
▼ Yes 2 □ No Director MD Baltimore 28a-f a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code Items 23a or 21223 USA 1404 Kuper Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? unk 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examiner once. 1 ☐XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: white Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HVAC plumbers helper unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eva Bush John Myer Sr ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1404 Kunner Place Baltimore, MD 21223 19a. Informant's Name/Relationship (Type. Print) 1404 Kuper Place Baltimore, MD Stephanie Myer/former wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 Nother (Specify) in state 4/16/11 Crestlawn Memorial Marriottsyille, Maryland 22 Neme and Addressor Fall board 6 Parker Funeral Home, P Baltimore, MB 2128, P 21. Signature of Edneral Service Licensee Mirector Balto. Md. Frederick Ave. d. 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between 23a. Part 1 Onset and Death Immediate Cause (Final disease or condition resulting in death) PURMON 14 **Physician** weele /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the attending physician and ched for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) page 2 should be detached Yes 2 🗌 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed has death? 2 No 2 No this certificate director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 **N**o 1 Yes 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: I or Attending Parter death. 1 Natural 5 Pending investigation s after death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Funeral D 29a. Certifier (check only 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the 1 within 2 To the 1 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

11595

State

31. Date filed (Month, Day, Year)

MD

MCDROW

Registrar's Signatur

4940

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1,20perPHYS,G914,4/12/2011,WS

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 10298 CHARD MICKLO Richard W. Micklo Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Glen Burnie Anne Arundel Baltimore-Washington Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F 8. Date of Birth **Funeral** Date of Bill. (Month, Day, Ye 11ne <u>14</u> Hours Min Year) 4.1941 Days 220-36-2010 Director Pennsylvania 69 June Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits notified at rector 1 Yes 2 No Maryland Anne Arundel Pasadena ۵ 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 2760 Bayside Beach Road 21122 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Rlack. White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Soldier U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Micklo Nellie Klimas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty S. Micklo (Wife) 2760 Bayside Beach Road Pasadena, Maryland 21122 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Crownsville V.A. Cem. 04/11/2011 Crownsville, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland Signature of Fuperal Service Licenses 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ ISCHEMIC CARDIOMYGPATHY disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 A No 26. Place of Death (Check only one) Be X ပ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 KResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 Pending 2 🗌 No death. 124 hours after death e Funeral Director: A leted filled in by the fo Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Richins D21336 1+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOZG RITCHIE HAY SUITE 134 ALBINO. KUHNUM PASADENA 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 8,2011 Physician/ B:10A. M Frances Naomi McVaugh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balto. Gilchrist Hospice <u>Towson</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Days Hours Min May 26, 1921 Pennsylvania 176-12-7170 89 Director Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. aţ Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. In the Company of the Maryla Important; If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified Md. Balto. Rosedale 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21237 5012 Springhouse Circle USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2X No If Yes, Give 21215-0036 1 ☐ Yes 2 ▼No Specify. 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Earnings Analysist Social Security Admin. 12th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Adam M. Kensinger Nancy J. Ebersol 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sposue David L. McVaugh 5012 Springhouse Circle Rosedale. md. 21237 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 A Burial 2 Cremation 3 Removal from State Gardens of Faith 4-12-2011 Balto. Md. 4 Donation 5 Other (Specify) Schimunek Funeral Home 21. Signature of Funeral Service Lio 22. Name and Address of Facility Shy D I 9705 Belair Road 21236 Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ 2 heimon conjustra disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ 40 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate I 2 - No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) VIOSO LC မ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 5 Pending after death. 2 🗌 No Investigation Accident Suicide the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29d. Date signed (Month, Day, Year) 58303 APRIL 8 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), houles ST (MV) 6701 TENISON MO 31. Date filed (Month, Day, Year) Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 308 M HERESA 2011 MOHR Medical 4a. Facility Name (if not institution, give street and numbers **Examiner** Town, or Location of Death 4c. County of Death Baxview Care Conter Saltimor, N/A Johns Hopkins If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛭 F Months Days Hours Min 215-34-7509 MARYLAND 1909 **Director** 101 Usual Residence of Decedent 28a-f show Director 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits 1 XYes 2 No MD N/A BALTIMORE 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 21206 USA 4242 SHELDON AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Black, White, etc. ö þ 1 Never Married 2 Married Yes 2 KNO Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: WHITE "natural", Specify: Completed 3 ♥ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) RESTAURANT COOK Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ರ PHILLIP GRIEBEL FRANCES SCHWARZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4242 SHELDON AVENUE BALTIMORE, MD 21206 JANET MOHR- DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4/11/2011 BALTIMORE, MARYLAND PARKWOOD CEMETERY 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME 6415 BELAIR ROAD BALTIMORE, MD 21206 23a. Part 1. Enter red disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each light Approximate Interval Between Onset an 1 Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical e to (or as a consequence of) Examiner IWK Sequentially liet conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury 7-104ear Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗀 No 1 TYPES Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗹 No Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending injury in 24 hours after deau...
The Funeral Director: Aft M 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#20b, c. perFH, G915, 5/10/2011, WS State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ llors an Medical **Examiner** 4a. Facility Name (if n County of Death anda Iston more Birthplace (State or Foreign Country) If Under If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours M 2 🗆 F 1) Yrs. Months (Month Day, Ye **Director** Usual Residence of Decedent show 10a. State with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No stown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 ✓ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 4005 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever ၉ 19b. Mailing Address (Street and Number or Rural Route Number, Important: If item 27 is any Injury or other trau lal/stown MD 21133 20b. Place of Disposition (Name of Care Parks of Parks of Parks of Other place) 20a. Method of Disposition Location - City of Town, State Department of Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Libert 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or beart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ocardral disease or condition resulting in death) come how Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a d be detached fi P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cancer 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? this certificate 2 No Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi DO0 22283 1105 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Lock Raven Blad. Baltimere, MD David J. Naiwas 5601 NO 21239 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Medical Town, or Location of Death **Examiner** asons Kandallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State 7. Age (In yrs. last birthday) **Funeral** Monting de 1 🗆 M 2 📝 F 5 Director ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Himore Yes 2 No 10e. Street and Num 10f. Zip Code 10g. Citizen of What Country? 21216 Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) should be filed within and Mental Hygiene. omestic Be 19b. Mailing Addre permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line disease, or complications that caused the death. Do not enter the mode of Approximate Interval Between Onset and Death Immediate Cause (Final Phylician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Prin Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4 Physician/ liza bet lears độ! 5:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie 105 Proctor Ct. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖼 F Months Days Hours Min. Aug. Dry7 Pear 925 Pennsylvania 214-20-6477 85 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🛛 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 United States 105 Proctor Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anna Amelia Howard Russell O. Rager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Proctor Ct., Glen Burnie, Maryland 21061 Linda Carol Keller / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 12, Catonsville, Maryland Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) ral Servi 21. Signa Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Phy ician/ disease or condition resulting in death) muocardi minu Medical (or as a consequence of) Examiner Sequentially list conditions, if any list fing to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy page 2 performed death? 2 No 1 🗌 Yes 2 Yes 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 28b. Time of 27, Manner eath 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred atural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 29c. License number 0 50 7 2 5 29b. Signaty

DHMH 17 Rev 7/2009

Registrar

Jenn, terk, 31. Date filed (Month, Day, Year) ans they Millers ville MD 21108

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** McCallum 07:00 M Alton 2011 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Medical Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days maryla 10 M 20 F 52 -68-0385 NOV. 30, 1958 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or itema 23s or 28s-f ehow 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location oriant: If item 27 is marked other than "natural; or itema 23a or 28a-1 show injury or other traumatic event, the Martical Examination at the multised at Yes 2 No ma Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Edward Son 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: 2 3 □ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Univer Elementary/Secondary (0-12) College (1-4or 5+) techicia OOR 1105 th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F Pages 1 and 2 should be mcCaelum Davi -daughte 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2::
Department of Health ar
Important: If Item 27 ie
any injury or other trau -in worth Callum Coppage 123 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State -18-2011 all 4 □ Donation 5 □ Other (Specify) dalli 21. Signature of Funeral Service Licensee 22. Name and Address of Facility md, 2122 Nance 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. M. Wallace Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) alveoldy hemorrhage Physician /Medical as a consequence of Examiner hepatic Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner use as the burial transit or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial tra-Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No 2 No 1 Yes 1 Yes After this certification, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 04/10/11 1235454703 and address of person who completed cause of death (Item 23a) (Type, Print) Jennilee Tuazon Baltimore, MO 21202 Paul Place 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 10:20 AM Nicholas Williams Margaret Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner +1 mor If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 01 05 g, Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Months Min. 1 □ M 2 💢F Days Hours Yrs. Director MD 36 - 528permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 PDes 2 No MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral South Bernice Ave 21229 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tech Assistant University Hospital <u>2th grade</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Henry Williams Mary Elizabeth Comegys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md 21229 Margaret Fisher-Daughter South Bernice Ave, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 4/13/2011 Woodlawn, 4 Donation 5 Other (Specify) 22. Name and Address of Facility
March F/H West Sign wre of Auneral Service Licensee 4300 Waash Ave, Baltimore, Md 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician/ days disease or condition resulting in death) Renas Hceele Medical Due to (or as a consequence of): Examiner clinical sepsis Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Urosepsis that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Division of Vital Récords, P.O. s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has tuneral director, page 2 s autopsy performed' 2 DMO 1 \sum Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be (26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer work? 1 ☐ Yes 2 ☐ No 1 Natural injury Accident 5 Pendina Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) P25483 PGYI MEDICAL RESIDENT 04-10-2011 PRIYAA VISWANATHAN, ST. AGNES HOSPITAL, 9003 COLTON AVENUE, BALTIMORE, ND 21229 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0^{M2}Pnth 20^Y 1^a1 Physician/ 0 6 g 9:45A Lennis Eric Newton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Joseph Ritchie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2 □ F Min Months Hours 0992077960 Maryland 212-82-1338 50 **Director** Usual Residence of Decedent 28a-f shov 10d, Inside City Limits 10b. County "natural", or items 23a or 28a-f sho 10a, State 10c. City, Town or Location death with the Maryland Director 1 X Yes 2 No Baltimore N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1009 N. Bentalou st. 21216 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examino once. Never Married 2 Married þ 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 Divorced 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Line Worker Tate 10th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Minnie Jackson Porter Newton Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 N. Bentalou St., Baltimore, MD 21216 Porter Newton III (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State on-site Crematory 04/07/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 230sephddr.offBrown Jr. Funeral Home PA MD 21217 2140 N. Fulton Ave., Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such Approximate shock, or heart failure. List only one cause on eigh line Interval Between et and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying consequence of To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deat. ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has t page 2 s performed? Yes 2 death? Yes 25. Was case referred to predical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: ျှ 1 Yeş 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury 5 \square Pending work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who combie State Registrar

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1	Examin	er	4a. Facility Name (if Stella Man	not institution CiS	, give street and nu	mber)		Timo		Location of Death	1	4	c. County o	Balti	imore
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	and show	ě	Usual Residence of 10a. State	Decedent 10b. County		100	c. City, Town or L	ocation						1	0d. Inside City Limits
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	Physician/		Immediate Cause (disease or condition resulting in death)	(Final	_ a. Ev	115	tace	Re	121	Duca	se				Onset and Death
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O. Box 68760	Physician: The law requires that the death certificate be this certificate has been signed by the attending physicismal director, page 2 should be detached for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2	months?		e Birth 2 🗆 egnant at tim	Fetal death 3	Ectopic		гу			23d. Date Mor		ery Day Year
P.O.	requires that the de been signed by the should be detached	y Phy	9 Unknown Part II. Other signif		ons contributing to	death but no	ot resulting in the	underlying	g cause giv	ven in Part I.	23e. Did	tobacco	use contri	bute to th	ne cause of death?
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Division		Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be 28e. Plac	ce of Injury - ding, etc. (Sp	At home, farm, specify)	street, facto	ry, office		28f. Location City or To			r or Rurai	Route Number,
_	Hospital or 24 hours afte Funeral Dir sted filled in	Medical	(Check 2	☑ Medical		asis of exami	nation and/or inv	estigation, i	n my opinio	on, death occurred	at the time, date	and pla	ce, and due	to the ca	use(s) and manner stated.
	Го the I within 2 Го the I	×	only one) 3 29b. Signature and		Nurse Practione	r. To the best	of my knowledge		curred at the Oc. License		ace, and due to t		e(s) and ma Date signed	-	
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	6		30 Name and addr	ess of person	who completed ca	use of death	(Item 23a) (Type	, Print)	N.1	But 1	/11/2	Pd	Tim	11)4 : 1	m D
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		_	State Registrar		Cer	tificate of L	Death	F	Reg. No.	3 4 7
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30%	Formarial		Howard County Gen 5. Social Security Number 6. Sex	7. Age (In yrs. last	hirthday)	Columb If Under 1 Year	ia If Under 24 Hrs.	8. Date of Birth	Howard	irthplace (State or Foreign
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9800	ırs after d ıral", or i Examin	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Fres, specily Cuba I ☐ Yes 2 🛣 No		nicari, etc.)	Black, Wh	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give I	dent's Usual Occup kind of work done o O NOT use retired)	ation during most of work	ing	16b. Kind of Busines	s Industry
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Maryl	2 should th and Me ?7 is marl traumati	- 3	19a. Informant's Name/Relationship (Type Michelle Williams-				and Number or Run	al Route Number,	City or Town, State, 2	
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99 xo	eath certificate t attending phys for use as the l		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de 4 Pregnant at time of dea	eath 3	Ectopic pregnand Other (specify)	с у		23d. Date of o	lelivery Day Year
O. B	the de by the ached	hysi	g 🗌 Unknown	9 Unknown						
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ord	w requ	plete	CORONARY A					24a. Was a	n 24b. Were a	autopsy findings available
Rec	rsician: The law s certificate has b lirector, page 2 s	Som						autops perfor 1 \sum Yes_	med? death?	es 2 \sum No
ta	ician: certific ector,	Be	25. Was case referred to medical examiner?	spital:	91	Oth	ace of Death (Chec			
of V	Phys er this eral dir	e: To	1 ☐ Yes 2 No		b. Time of	at 3 □ DOA □	4 ∐ Nursing Hoy y at		ence 6 Other (Spe	ecify)
ono	ending eath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 1 □	? Yes 2 \square No			C.C. charles
Division of Vital Records, P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. On the Funeral Director. After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (St City or Town	treet and Number or F n, State)	Tural Route Number,
_	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check Medical Examine)	ian: To the best of my knowledger: On the basis of examination an	nd/or invest	tigation, in my opinio	on, death occurred a	t the time, date an	nd place, and due to the	e cause(s) and manner stated.
	To th withir To th	2	29b. Signature and title of certifier		iomodgo, c	29c. License	e number	2	29d. Date signed (Mor	oth, Day, Year)
			> 8n	pleMO		00	05315	0	APRILS	2011
)			29b. Signature and title of certifier 30. Name and address of person who com Shawara 31. Date filed (Month, Day, Year) APR 1 2 20	npleted cause of death (Item 23	(Type, P	So Ler	strajo	Rd	Suite	110 MD
	Stat Registra	_	31. Date filed (Month, Day, Year)	32. Redistrar's Signature	8. 4	backer			-	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items 20a-c, 22 per fh g915 5-5-11 yt. State of Maryland / Department of Health and Mental Hygiens 0 1 1 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician ERBERT 011 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore HCR Manor Care Catonsville Catonsville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Trinidad 8. Date of Birth (Month, Day, AUg 29, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** ^{Yea}r) 1939 Months Days Hours Min. 1**∑**M 2□ F Yrs. 71 Director 577**-**78**-**2114 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Evantine is ust be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√∏ No Funeral Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 3200 16th Street NW 20010 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1 □Yes 2 X No Black, White, etc 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Be Completed by 3 ☐ Widowed 4 🎇 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) education teacher 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Charles William Priam P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10801 Enfield Drive #104 Woodstock MD 21163 Gloria L. Patty/cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 ▼Other (Specify) in state Baltimore, Md. On Site 5-1-11 22. Name and Address of Facility March FH. West 21. Signature of Funeral Service Licensee
Ronald S. Wash , Airector State 4300 wabash Ave Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death **Physician** YEMA ZUBDURAL disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions. Physician/Medical Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) the detached 9 Unknown ģ neral Director: After this certificate has been signed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) within 2. and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059107 04-04-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE REISTS RYFWN, MD Ump BUSINESS CENTER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 2 2011 Registrar

11-02/08 Anthony Joseph	Per	Please Type o	of Maryland / D					Jible.	11716
maiony occopii		1- For State Registrar		Certificate		a Wientan II		g. No.	
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Las Anthony Joseph					2. Date of Death Month April 9, 20	Day Year	3. Time of Death 0113 hrs
)		4a. Facility Name (if not institution, given 1131 N. Fulton Avenue	street and number)		4b. City, Town, or I Baltimore	Location of Death		4c. County of Death N/A	
Funeral Director		5. Social Security Number 216-02-1914 6. Se	x 7. Age (In 4.	yrs. last birthday)	If Under 1 Year Months Days			h(MM/DD/YYYY) 9. Birtl 3 / 6 7 Foreign Cou	nplace (State or MD intry)
*ny	Ī	Usual Residence of Decedent 10e. State 10b. County	100	c. City, Town or Loc	ation				10d. Inside City Limits
>	ğ	MD N/A		Baltimo:	re			g. Citizen of What Coun	1 Yes 2 No
the Mary Sa or 28a	Director	10e. Street and Number 2124 Wilkens A	ve,		10f. Zip Code 2122	3		USA	uyr
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f show injury or other traumantic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2	It	Vas Decedent of His Yes, specify Cuban Yes 2 X No	Mexican, Puerto		14. Race - Americ A f Y Lican A f Y Lican Amer Specify:	
036 Ithin 72 hours a ne. r than "natura Iedical Exami	Completed b	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	ly highest grade complet College (1-4 or 5+)	during	ent's Usual Occupati most of working life. Installe	DO NOT use reti		16b. Kind of Business/li Furnitur	-
215-0 of filed wintal Hygie ked nther	Be Col	17. Father's Name (First, Middle, Last) Joseph Perkins		•	. 1	18.Mother's Name Edith	(First, Middle, M Sheppa		
AD 21, 2 should E and Men 27 is mar matic eve	10	19a. Informant's Name/Relationship (T Janice Perkins	/Wife	19b. Mail 212	ing Address (Street 4 Wilken	and Number or F S AVe, I	Rural Route Num Balt., N	ber, City or Town, State, ID 21 223	Zip Code)
TOFE, Pages I and ent of Health in: Witem		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State		osition (Name of cent other place) On Cem.	netery, 4/	Date 15/11	20c. Location - City or Balt., MD	Γow∩, State
Baltir permit. I Departm Imports	7770	21. Signature of Funeral Se ce Licen		5	126 Bela	ir Rd,	Balt.,N	Close F.Sv 4D 21206-5	7C,PA 5105
Physician /Medical		23a. Part I. Ent the disease, or comp failure. List only one cause on ea Immediate Cause (Final disease a.	ch line.	death. Do not ente		such as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
£xaminer		The state of the s	Oue to (or as a conseque	ence of):					
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conseque						
cuted and transit	cal Examiner	events resulting in death) Last d.	Oue to (or as a conseque				11 / 00	11	
O, be exe sician a		X UNPENDED			7,28a-f pe	r me gyl	4-22-		
P.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of the Live birth Pregnant at time Unknown	2	Fetal death 3 [Other (Specify)	Ectopic pregna	ancy	23d. Date of delivery Month D	ay Year
P.O. B s that the d speed by the	by Phy	Part II. Other significant conditions Cocaine Use	contributing to death bu	it not resulting in th	e underlying cause g	iven in Part I.		bacco use contribute to	_
Division of Vital Records, P.O. Box to a rate ding Physician: The law requires that the death as after death. **I Director: After this certificate has been signed by the atterled in by the fumeral director, page 2 should be detached for u	Completed by	- Occurre obc					24a. Was a autops perform	sy prior to c med? death?	opsy findings available ompletion of cause of
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Vital hysician: hysician: this certifi	o Be	1 Yes 2 No	ospital: 1 Inpatient					Residence 6 🗸 Other	Scene
n of Vij ding Physi h. After this	D: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time o	1101	y at Work? ′es 2 🛣 No		now injury occurred	
ivision of Vital I nr Attending Physician: After death. Director: After this certifi i in by the funeral director.	Certification:	2 Accident Investigati 3 Suicide 6 X Could not	28e. Place of Injury		reet, factory, office b		unkno 28f. Location (S or Town, St	wn treet and Number or Ru tate) 1131 N.	ral Route Number, City Fulton Ave.
Division of ' Division of ' To the Hospital ar Attending Ph within 24 hours after death. To the Puneral Director: After t completely filled in by the funeral			an: To the best of my kn On the basis of examina	owledge, death oc	curred at the time, da		due to the cause		
Tot with Tot com	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licenso		_	29d. Date signed (Mor	nth, Day, Year)
of which		30. Name and address of person who					- MD 24004		
01-lic	ate	Patricia Aronica-Pollak MI 31. Date filed (Month, Day, Year)	32. Redistrar's		111 Penn St	reet, Baitimoi	e, MD 21201	<u> </u>	
Regis	161	TILL IN LUII WENT	~ ~ / / / / / / / / / / / / / / / / / /	-					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death June Vivian Pardo April Physician/ 7 Pay 2011 4:00A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Harford Garden ecurity Number -12-8040 . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) PA (Month Day Year) Days 1 M 2 XF Months Hours Min 87 Director 03/16/1924 Usual Residence of Decedent 28a-f show 10a. State 10b. County than "natural", or items 23a or 28a-f sho he Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5918 Plumer Avenue 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Yes Yes Yes, Give 2 **X**Vo Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Legal and Mental Hygien is marked other ti Secretary Law Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Grace Brown Maiden Surname) Paul Morris ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $r=5918\ Plumer\ Ave.,\ Baltimore,\ MD$ ge 1 and 2 shart of Health a Paula Renee Pardo /Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 d
Department of I
Important: If its
any injury or of 1 🗆 Burial 2 🛭 Cremation 3 🗀 Removal from State 4/9/2011 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. Woodbine, MD 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Cremation Services Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav been signed by the should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? Yes 2 N certificate 2 🗆 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 1 Yes 2**X** XNO ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred XXNatural work 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signat 29d. Date signed (Month, Day, Year) ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name a State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		For State	Certii	ficate of L	Death		Reg.	No.			
Physician	/ 1	Decedent's Name (First, Middle,Last)	quell Jo	shua	Pina		2. Date of Death Month April 9, 201	ay Year	3. Time of Death 0919 hrs		
	4	la. Facility Name (if not institution, give street and 7129 Natures Road	number)		. City, Town, or L Columbia	ocation of Death		4c. County of Deat Howard	h		
Funeral Director		Social Security Number / A 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24Hrs. Hours Min.		/ 1995 Forei			
Aaryland 28s-f show any 1 at once.	1	Jsual Residence of Decedent Oa. State 10b. County MD Prince Geo		own or Location	Lau	rel	1100	. Citizen of What Cou	10d. Inside City Limits 1 X Yes 2 No		
the Maryland is or 28a-f sh tiffed at once		11348 Laurel Wal	k Drive		10f. Zip Code 20	728	109	USA			
5 72 hours after death with the Maryland m "natural", or items 23a or 28a-f sho al Examiner must be notified at once letted by Elinaral Director			/ear	If Yes	s, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 No specify: specife lack						
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner		15. Decedent's Education (Specify only highest of Elementary/Secondary (0-12) 12 9 College	rade completed) 1 9 (1-4 or 5+)	during mos	S Usual Occupation of working life. I	DO NOT use retir	ed)	6b. Kind of Business	/Industry		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica		7. Father's Name (First, Middle, Last) Cornell Anthony Ri	chardson			Va	(First, Middle, Ma Nessa	Pina			
MD 2121 d 2 should be fi lth and Mental n 27 is marked numatic event,		9a. Informant's Name/Relationship (Type, Print) Cynthia Price / Au	nt	19b. Mailing A 7129	Address (Street Nature	and Number or F		er, City or Town, Stat NDia, MD			
S 1 an of Hea		20a. Method of Disposition 1 ☐ Burial 2 ☑ Feremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other Specify:	I from State Fina	al Jour	ney Cren	n. 4/1	2/2011	Woodbine,	MD		
	T.	21. Signature of Funeral Service Licensee Dor	KING	M = 1	PO Box	1413.	Baltim	ore, MD	21203 Approximate Interval		
Physician /Medical £xaminer	1	Failure. List only one cause on each line. Immediate Cause (Final disease a. Codeine Intoxication									
		Sequentially list conditions, b	s a consequence of): s a consequence of):								
ted nsit	Yallill	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or a	s a consequence of):								
ficate be executed g physician and the burial - transit		© UNPENDED #15 perFH, G916,6/17/2011, WS 23,27,28a-f,g915 5-12-I1 sm									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director and the funeral	AMENDED 23,27,28a-f,8915 5-12-II sm IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 4 Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to										
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Division of Vital Records, P.O. tall or Attending Physician: The law requires that it are death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Completed						24a. Was ar autops perforn 1 Yes 2	y prior to ned? death?	autopsy findings available completion of cause of		
tal Recions: The certificate ector, page		25. Was case referred to medical examiner?	1			of Death (Check	<u> </u>	tesidence 6 🗸 Oth	ar: Scana		
n of Viding Physical After this funeral dir	₽ -	1 ✓ Yes 2 No 27. Manner of Death 28a. D (M	ate of Injury onth, Day, Year)	R/Outpatient 28b. Time of Inj	jury 28c. Injur	y at Work?	28d. Describe ho	ow injury occurred tal codein ation			
Division of Vital Rectivities to the Hospital or Attending Physician: The within 24 hours after death. The the Funeral Director: After this certificate completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. F	$4-9-11$ 1 lace of Injury - At hon $i^{(fy)}$ single	ne, farm, street	, factory, office b		28f. Location (St	reet and Number or Fate) 7129 Nat	Rural Route Number, City		
the Hospit hin 24 bour the Funer.	<u> </u>	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the ba	best of my knowledge sis of examination and	e, death occurre	ed at the time, da	ite and place, and death occurred	due to the cause	(s) and manner as st	ated. the cause(s)		
ok pend	¥e	29b. Signature and title of certifier	Stated.			29c. License number 29d O.C.M.E. Ap			fonth, Day, Year)		
6'	-	30. Name and address of person who completed Melissa Brassell, MD Assistant	cause of death (Item 2		enn Street, B	altimore, MD	21201				
Sta	~		. Regurar Signature	1 11	adel						
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amend 1 tem 5 per and Bepartment of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011Murphy Post April 5:00 A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living Columbia Howard 5 Social Security Number 220-If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
April 16,1928 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1 M 2 X F Country) Maryland Director 82 223-24-5032 Usual Residence of Decedent show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Timonium Marvland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 117 Castletown Road, Unit 302 21093 USA buld be filed within 72 hours after death of Mental Hygiene. marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify. Completed 3 Divorced 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home n/a Be permit. Page 1 and 2 should be flex
Department of Health and Mental Hy
Important: If item 27 is marked oft
any injury or other fraumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Wilson Cecilia Genevieve McGuire Pau1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin P. Murphy/Son 314 Presway Road, Timonium, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Speging) Owings Mills, Maryland Maryland Veterans Cemetery Signiture of Furleyal Repvice Lidense 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 Part 1. Enter the disease, or complications that shock or heart failure. List only one cause on aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
2 Years Immediate Cause (Final Physician/ Years disease or condition resulting in death) Alzheimers Disease Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 brours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li retail 452.

Pregnant at time of death in the past 12 months?

1 Yes 2 X No
9 Unknown Month Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Pelvic Malignancy 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) Assisted 2 X No 7 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100 April 8, 2011 D50531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Snowden River Parkway, #301, Columbia, MD 21045 Harry Li, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Denve S. fares

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APPIL PIZKINS Physician/ TH 7/11 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** OWSER CKERSGILL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. Dec 16, 1 🗆 M 2 🕱 F 1924 Mary land Director 86 218-14-0554 Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Tes 2 X No Towson Maryland **Baltimore** 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number "natural", or items 23a or Funeral 615 Chestnut Avenue 21204 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married <u>Ş</u> Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) 12 04 Managers Aid **Book Bindery** of the state of th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit, Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Irene **Estelle** Majors Damm John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21769 John C. Damm/Nephew 105 North Pointe Terrace, Middletown, MD Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4/12/11 Donation 5 Other (Specify) Sherwood Church Cemetery Cockeysville, MD Signature of Francial Service Lice 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 see Bryan W. Clary 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause of each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ DAMPNTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months ō Month Day 5 Other (specify) Year signed by the at the detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 → No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy certificate 25. Was case referred to medical **Division of Vital** Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner' Other: 1 Tes 2 100 ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending n 24 hours after death.

e Funeral Director: After the function of the functin 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifie ause of death (Item 23a) (Type, Print) d address of person who completed 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** 0317 AM Florence Restivo 4621 05 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore N/A St. Agnes HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🔀 F 216-18- 0288 89 Yrs. Oct. 1922 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Illimportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in a Modical Evanting must be a particulated. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1823 Frederick Avenue 21223 United States Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. 2 White 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker N/A Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Boteler ပ Barbara Luskorn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gino Restivo - Son 1244 Sulphur Spring Rd., Arbutus, MD 21227 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date ☐Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation A5 ☐ Other (Specify) Arundel CrematoryApr. 9,2011 Odenton, Signature of Ferrigal Service Lider 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Astery Disease

Due to (or as a const juence of): Day **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 □Yes 2 No 2 🗆 No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1☑Yes 2□No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 04/05/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. Caton Avenue, Baltimore, MD 21229 Anii Nadipelli 2. Registrar's Signature 31. Date filed (Month, Day, APR 1 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 'S M HUDES IL NRE Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 24 Months Days Hours Min. (Month, Day, Year) 219-22-4919 Director 82 Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location must be notified at 10d. Inside City Limits Director MD 1 Yes 2XXNo Anne Arundel West River 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 5115 Holly Drive 20778 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceud. Armed Forces? 12 Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify. Specify: White "natural", Completed XX Widowed 4 Divorced other than "natu 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene.
27 is marked other than traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Education 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eventoe. ပ Norman William Seifert Mildred Limerick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard Rhodes / Son Millersville, MD 21108 275 Pinewood Road 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place, XXX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/11/2011 Cedar Hill Cemetery Brooklyn, MD 22. Name and Address of Facility Singleton Funeral & Cremation Sign up of Funeral io Licensee M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 At - Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart failure. List only one cause on each line. iset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). physician and the burlal-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha Hospital or Attending Physician: The 1 Yes 2 No Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: Natural 28d. Describe how injury occurred iniury work? 1 🔲 Yes 5 Pending 2 No Investigation Accident Suicide 6 Could not be within 24 hours after de **To the Funeral Directo** completed filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 □ Certifying Nurse Practioner: To the best my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) leted cause of death (Item 23a) (Type, Print) a Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marlene Elsie Richardson APRI 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ARUNDEL GLEN BURNIE WASHINGTON MEDICAL ANNE BALTIMORE ENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2**X** F Months Davs Hours Min 1077874933 Maryland Director 213-30-9647 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h. County 10d Inside City Limits 10c. City. Town or Location Director 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21060 207 Saltgrass Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black White etc. Yes 2 XNo "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Madeline Mary Schneider Puncochar Frank RICHARDSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 207 Saltgrass Drive Glen Burnie, MD 21060 Mr. Jody Richardson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aprilate 12 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Brooklyn, MD Cedar Hill Cemetery 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funenal Service Licer Signature ... Services PA 1 2nd Ave SW Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying and -transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last g physician a Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy this certificate has performed? Yes 2 No 1 Yes 2 No Division of Vital hin 24 hours after death.

the Funeral Director: After this certific
ripleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 **X** No 1 Tes <u>م</u>| 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No injury 5 Pendina Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24

To the F

complet only one) 29b. Signature and title of 29c. License number who completed cause of death (Item 23a) (Type, Print State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RAHLINGS APRIL Physician/ EARL 2011 17:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Columbia 4c. Gounty of Death **Examiner** Howard Co Medical Center Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 **XX**M 2 □ F Months Days Hours Min No₩°27, 71962m Marviand 220-78-7910 Director Usual Residence of Decedent 28a-f show 10a State 10b. County 10d. Inside City Limits Ħ 10c. City, Town or Location Laurel Director Prince George ral", or items 23a or 28a-f s Examiner must be notified Md1 🗆 Yes 2 🏝 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20724 Funeral 52 South Paula St 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc Completed by 1 Never Married 2 Married Caucasian Baltimore, Maryland 21215-0036 1 Yes Z No Specify "natural", 3 Widowed 4 X Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) Electrical Services College (1-4 or 5+) Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental | Important: If item 27 is marked o any injury or other traumatic even Earl Howard Rawlings ပ္ Shirley Ann Hutchinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 52 South Paula St Laurel Md 20724 Jessica M Rawlings (Daughter) 20c. Location - Ci Clinton Md 20a. Method of Disposition 20b. Place of Disposition (Name of Date City or Town, State Lee Crematon or other place) 1 Burial 2 Cremation 3 Removal from State 4/10/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home 21. Signa are of Funeral Service Lice 6633 Old Alexandria Ferry Rd Clinton Md 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1)ISEASE Physician/ JAKOB CREUTZFELDT-MONTHS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): 18 Exami attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown g 🗌 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death. signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XXUnknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 1XX Yes 1 ☐ Yes 2XX No certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🖪 No Hospital 1 🔲 Yes ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 XXNatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Å Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D0070598 1 Ohin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahin Choudhury MD 5755 Cedar Lane Columbia Md 21044

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 4:00P^M April 2011 Christopher Lee Rose /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4901 Pennington Avenue Anne Arundel Curtis Bay If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Min. Days Hours Months 11X1M 2□ F Yrs. West Virginia 08/16/1976 212-92-3130 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or Itams 23a or 28a-f ahow the Medical Examinar must be notified at 1 X Yes 2 □ No Director Anne Arundel Curtis Bay 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 4901 Pennington Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or Itan any Injury or other traumatic awant, the Medical Exeminations. Black, White, etc. 1 X Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 🛭 No Specify: Specify. ğ 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Service 12 Bus Boy Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Rose Dorothy Geoghegan James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4901 Pennington Avenue, Curtis Bay, MD 21226 Verna Hartlove / Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 04/07/2011 Hanover, Maryland Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANCER YEHRS IMETASTATIC **Physician** COLON /Medical Due to (or as a consequence of): Examiner Sequentially liet for filters if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner sician and burial-transit Due to (or as a consequence of): Box 68760, Hospital or Attanding Physician: The law requires that the death certificate be as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day atter Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2XNo Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred death. 1 ☐ Yes 2 ☐ No investigation Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined hin 24 hours after de the Funeral Diracto inpletely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2.

To the F

Registrar DHMH 17 Rev 1/2001 Suite 106

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mid.

0,216EC

31. Date filed (Month, Day, Year)

29c. License number

1406 S.CRAIN HWY

29d. Date signed (Month, Day, Year)

GLEN BURNIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Joseph Reinhart, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Date of Day, Ye (Month, Day, Ye Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 1 🔀 M 2 🗆 F Months Days Hours Min. Director 38 257-59-8805 Georgia December Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2X No Montgomery Germantown Maryland 10f. Zip Code 10g. Citizen of What Country? 21331 Emerald Drive 20876 United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. and 2 should be filed within 72 hours aft Health and Mental Hygiene. tem 27 is marked other than "natural", Specify: White 3 Divorced 4 Divorced Year or Dates REINHART 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Legal Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Joseph Reinhart, Virginia Ann Iseldyke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 Is any injury or other trau once. 21331 Emerald Drive, Germantown, Maryland 20876 Thomas Reinhart/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of April 11, 20c. Location - City or Town, State cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 Haran M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line ediate Cause (Final ase or condition Immediate Cause (Final disease or condition resulting in death) Onset and Death wa lory Physician/ Medical Examine ellmone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has the funeral director, page 2 s autopsy cerformed' 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after death To the Funeral Director; 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Pranticiper: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certi 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANALES

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2 201

JOSEPH

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1030 am Scheidegger Faye Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death timore Grenera If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 1 M 2 X F Feb. 24, 1946 Hours Maryland Director 214-48-0622 65 Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Baltimore Lansdowne 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 5th Avenue 21227 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examit ury or other traumatic event, the Medical Examit Specify: White 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Waitress Food Service Be 17. Father's Name (First, Middle, Last) aryland 18. Mother's Name (First, Middle, Maiden Surname) ည John Allan Brannon Margaret Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Scheidegger Sr.-Husband 630 5th Avenue Lansdowne Maryland 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place 1 Burie 2 X Cremation 3 Removal from State Apr.11,2011 Glen Burnie Maryland tion 5 Other (Specify) Atlantic Crematory 4 Don of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home of Lansdown 2719 Hammonds Ferry Road Lansdowne Maryland 2122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ myocardial Acute 30 min Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1XYes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) xamiper? Other: 은 2 🗀 No 1 Inpatient 2 R ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation

Could not be 2 🗌 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of n knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 who completed cause of death (Item 23a) (Type, Print) ntaw St Suite 405 Belto, mD State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20c per fh g914 4-12-11 vt State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. Rosalie Stanley ĪĎ 2011 8-33A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Baltimore Towson . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, Hours Min. 216.36.9706 1 □ M 2 💢 F Months MD Director 07/68 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified Baltimore MD 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2013 Cecil 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 2 No 1 Yes If Yes, Give 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 XNo Specify: Black 3 Widowed 4 Divorced Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Domino Sugar, College (1-4 or 5+) Elementary/Seconday (0-12) perator 9th grade Machine æ Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Robert Stanley Mildred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue Baltimore MD Department of Health Important: If item 27 any injury or other the 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pikesville, Md. Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Druid Ridge Cemetery 18 041 4 Donation 5 Other (Specify) C. Greene Puncal services 21. Signature of Funeral Service Licenses Vaughn Road andallstewn MD 21133 23a. Part 1. Enter the idisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition nset and Death Physician/ NN COLORI Medical resulting in death) Due to (or as a consequency of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Frier underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atte should be detached for in the past 12 months? Pregnant at time of death 1 Yes 2\square
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 21X No 1 \square Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy To the Hospital or Attending Physician; The I within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending iniurv Accident Investigation 2 ☐ Acciden 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Spellman 7:33 PM Clinton 201 Donil **Medical** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 6 Deauville Court, Akesville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** 215.28.3924 1 X M 2 D F Months 1211911932 Country) **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Akesville Rathmone 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21208 6 Deauville Court, Apt. 23 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo Specify: Completed 3 - Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Enchanted Herb (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Tea Room Self Employed 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles B. Spelman Kizzio M. Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trina Myra Citixton / Daughter Endora Court Owings Mills MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 0413 2011 Baltimone, MD Greenmount Cremating 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vauhn C. Greene Funeral Scrices Liberty Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Physician/ ertensive Carpierarentar Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Obstructive Pulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 0 10 1 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 Yes 2 🗌 No ☐ Accident ☐ Sulcide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 11,2011 H 63088 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21208 V135 1838 Greene Tree Road Gold Do

State Registrar 31. Date filed (Month; Day, Year)

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11-02703 Elisabeth Szczep	ans	Please Type	or Print in Bla te of Maryland /	CK Ind	delible ii	n K. Ens i Health a	ure All C and Men	Jopies A Ital Hygie	re Leg			
Elisabetii Szczep		I- For State	le of ivialylatio /		tificate of		aria ivieri	itai riygic		1. No.	n. After	173
Physicia		Registrar 1. Decedent's Name (First, Middle,	_ast)						te of Death			. Time of Death
Medical Examin		Elisabeth Sz	czepanski					Ap	onth oril 8, 201	1		2101 hrs
		4a. Facility Name (if not institution,	-			4b. City, Town Glen Bur		of Death		4c. County of		
	4	Baltimore Washington I 5. Social Security Number 6		In ure la	st birthday)	If Under 1		er 24Hrs. 8. [Date of Birth	(MM/DD/YYYY)		place (State or
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with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number				10f. Zip Cod	le		10	g. Citizen of Wha	at Country	y?
3a or otifie		2109 Piney Bran	ch Circle, A	pt.			21076			United	Stat	
h with	Funeral	11. Marital Status 1 Never Married 2 Mar	12. Was Decedent E	ver in U.S		s Decedent of es, specify Cu				14. Race White		n Indian, Black,
r deat	뒤		1 Yes 2 X	No	1	Yes 2 🛣	No enecific			Specify:	Whi	te
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2 hou	흁	Elementary/Secondary (0-12)	College (1-4 or 5+		during m	ost of working	life. DO NOT	use retired)				
D36 thin 7 ne.	Completed		3			Unemp	oloyed				N/A	44.
5-0 led wi other		17. Father's Name (First, Middle, L						. `		aiden Surname)		
121 l be fi ental	å	Adam J. Szczepanski Susannah Stanton 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,						State 7	'in Code)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	의	Susannah Stanto										MD 21076
and 2 ealth cealth tem 2 traum		20a, Method of Disposition	II / HOUNCE		lace of Dispos	ition (Name of		Dat		20c. Location -		
Ore ges 1 it of H	-1	1 Burial 2 X Cremation		' I	rematory or ot	her place) Matory	Tno	0/1/11/	2011	Raltimo	ro 1	Maryland
ti. Pa		4 Donation 5 Other Spe 21. Signature of Funeral Service L	censee A vson K	Tav	or 22.1	Name and Add						
Depa Depa		Alaki Tak	A your k	Lay						re, Mar		
Physician		23a. Part I. Enter the disease, or ca failure. List only one cause o		e death.	Do not enter t	he mode of dy	ing, such as o	cardiac or resp	iratory arre	st, shock, or hea	irt	Approximate Interval Between Onset and
/Medical	- 1	Immediate Cause (Final disease	a. Alcohol I	ntox	icatio	n						Death
Lammer		or condition resulting in death)	Due to (or as a conseq	uence of):							
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lox 68760, can certificate be execute a strending physician and for use as the burial - tranfor	ğ		AMENDED 23a			per me	g914 4	-20-11	VL	23d. Date of	delivery	
876 tificat ng ph	<u> </u>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birth	or pregn		etal death	3 Ectopi	ic pregnancy		Month	Day	y Year
Box 68760, e death certificate but the attending physic ed for use as the but	sicia	1 Yes 2 No 9 ✔ Unkn	4 Pregnant at ti	me of dea	ath 5 O	ther (Specify)						
. BC he dez	Physician/Medical	Part II. Other significant condition	0	nut not re	sulting in the	underlying cau	se given in P	art I.	23e. Did tol	pacco use contri	bute to th	e cause of death?
ires that the signed by	<u>a</u>	Part II. Other signmount conduct	ins Continuating to death.	301110110	Journal of the Land	andonymig oza	g.ve.v.		1 Yes	2 No 3	Probal	bly 4 🗹 Unknown
ords,	B B							— ŀ	24a. Was a			psy findings available
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ing Physical directed dispersed dispersed to the dispersed din dispersed dispersed dispersed dispersed dispersed dispersed dis	٩ !	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	,	28b. Time of		Injury at Wor			ow injury occurre		
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Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been similar by the funeral director, page 2 should be in by the funeral director, page 2 should	Eg	2 Accident Invest 3 Suicide 6 X Could	gation 28s Place of Initi				ice building, e	tc. 28f.		treet and Number		al Route Number, City
Div pital o purs af purs af	Certification:	4 Homicide determ			at	home			#562		er,	ey Beach Md.
		29a. Certifier 1 Certifying Phy	sician: To the best of my iner:On the basis of exam	knowledg	ge, death occu	rred at the tim	e, date and pl	lace, and due	to the cause	e(s) and manner	as stated	d. cause(s)
To the within To the complete	Medical		and manner stated.	a lation af	CO HIVESHIGE	_	cense number		o, date e	29d. Date sign		
	21	29b. Signature and title of certifier				230. 210	,			l	4	2 2

DRMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

Donna M. Vincenti, MD Assistant Medical Examiner

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 10, 2011

Baltimore, Maryland 21215-0036 Box 68760 P.O. of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #1State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ KARL F. SCHEIGHT Month Karl F. Segeidt 8:50 PM M March Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death North Arundel Health & Rehab Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Aug 23, 1 🛛 M 2 🗆 F Hours Min. Year) 935 **Director** 181-28-8045 75 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Glen Burnie 10e Street and Number ö 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 21060 USA 8103 Stone Haven Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married within 72 hours after white If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Widowed 4 X Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 18b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) pool rooms manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Magid/friend 8103 Stone Haven Drive Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other (Specify) in state ture of Euneral Service Licensee State and Addressivac Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) EYUM AMU Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ng physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death ate has been signed by the apage 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📜 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 XNo Yes 2 No 1 Tes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 \sum Yes Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and

State Registrar 31. Date (led (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March]7, Day 2011 Year Vincent Gearld Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Saint Thomas Moore Facility Hyattsville 5. Social Security Number 7. Age (lg yrs. last birthday) If Under 1 Year If Under 24 Hrs. Sex 12 M 2 □ F 8. Date of Birth **Funeral** Year 1941 Months Days Hours April Day Director 220-38-1632 Yrs. Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location
Upper Marlboro 10a. State 10b. County should be filed within 72 hours after death with the Maryland Director MD Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20774 2121 Samsbury Road Funeral 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc ģ 1 Never Married 2 Married Specify: Black ☐ Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Environmental Service 0ccur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Smith Carrie Johnson and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth a Important: If item 27 is any injury or other trai Darryl Smith 2121 Samsbury Rd Upper Marlboro, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Riverdale Crematory 1 Burial A Cremation 3 Removal from State 04/06/20]] Riverdale, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dunn & Sons 5635 Eads Street NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Cardiovascular Hujuosduone Physician/ Medical resulting in death) **Examiner** Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by nutuna Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes ျဉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) 2006 368 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4:05 AM

Prince George's

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

Washington DC

20774

Dav

2 No

1 Yes

Year

20019

Washington, DC

Onset and Death

AMEND #30 RER DVR G914 4/12/2011 JH State of Maryland Department of Health and Mental Hygiene

DHMH 17 Rev 7/2009

State Registrar AJIT KURUP

31. Date filed (Month, Day, Year)

HYATTSVILLE, MD

20783

1835 UNIVERSITY BLVD

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 0-40 AM Michael E. Swigert Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner n/a Baltimore Union Memorial Hospital 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number **Funeral** 1 XM 2 □ F Davs Hours Min (Month Day Year) 10/1/1951 OH 59 Director 268-52-9894 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County Director 1 ☐ Yes 2 No PAYork Etters 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 17319 155 Black Walnut Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates. 1968–1984 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Third Mate Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Dolores Imogene Short George Louis Swigert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PA 17319 Rosemary Y. Swigert/Wife 155 Black Walnut Dr., Etters, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State Carroll Crematory 4/11/2011 | Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Burrier-Queen Funeral Home & Crematory, ama 1212 W. Old Liberty Rd., Winfield, MD tri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Massive Myocarcdia Immediate Cause (Final Intarction Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): 1 day Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events at this independent) July to (or selections ignition of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has After this certificate within 24 hours after death.

To the Funeral Director, After this certific: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 19 2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fahmi Rahman UNIVERSITY PARKWAY, BALTIMOREMD21218 E UNION MEMORIAL 31. Date filed (Month, Day, Year) 32. Res State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Please Type or Print in State of Marylar 1 - State	nd / Depa		Health and	Mental Hyg	giene	
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Doreen Simms		incate or i	Deam	2. Date of Dea	Reg. No. / I I I I I I I I I I I I I I I I I I	3. Time of Death 5.14 9 M
C	Examin	_	4a. Facility Name (If not institution, give street and number) 6000 Samapitan		4b. City, Town, o	Location of Death	1 //	4c. County of De	ath
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. In 12 M 2 12 M 2 12 M 2 12 M 2 M 2 M 1 M 2 M 12	-	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	, Year) C	irthplace (State or Foreign ountry)
	show dat	tor		ty, Town or Loc			11/0/	0.5	10d. Inside City Limits
	he Maryl or 28a-f e notified	Funeral Director	MD N/A Ball	Ltimor	E 10f. Zip Code			10g. Citizen of What C	1 ★ Yes 2 □ No
:	ath with t	uneral	3819 Woodley Ave - Apt. 2 11. Marital Status 12. Was Decedent Ever in U.	c 12 V	21206	lispanic Origin? (Sp		USA	·
9200	rurs after dec tural", or ite al Examiner	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 3 😨 Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 💟 No If Yes, Give Year or Dates.	lf 1	Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	14. Race - Am Black, Wh Afric Specify: Ame	ite, etc. can
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At the filem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+)	(Give k	lent's Usual Occup kind of work done O NOT use retired) Omemake	during most of wor	king	16b. Kind of Busines Self	s Industry
rland	d be filed Aental Hy Irked oth tic event	To Be	17. Father's Name (First, Middle, Last) Robert Ypoung			18. Mother's Nar Shirley	ne (First, Middle, I ' Mann	Maiden Surname)	
Mary	d 2 shoulk alth and Λ 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Donney Jefferson/Common la	19b. Mailin w 381	g Address (Street 9 Woodl	and Number or Ru .ey Ave-	ral Route Number Apt. @	City or Town, State, 2 , Balt., MI	(ip Code) 21206
more	Page 1 an nent of He ant: If iten Iry or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Place of Dispos cemetery, crem YView	sition (Name of natory or other place Cremate	ory 4/1	Date 2 / 1 1	20c. Location - City of Balt., M	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	²² . 51	Name and Addre	ss of Facility Ha:	ri P. C Balt.,M	lose F.S D 21206-	vs PA 5105
D.	hysician/		23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final		r the mode of dyin	-	or respiratory arre	est,	Approximate Interval Between Onset and Death
()	Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of the consequen		ance				
V 2	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or ilinjury	uence of):					
		cal Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of the con	uence of):			-		
. 68760	ing phys	/Medic	IF FEMALE:						
	requires that the death certificate is been signed by the attending physishould be detached for use as the	Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of constitutions of the pregnant at time of co	al death 3 🗌	Ectopic pregnand Other (specify)	cy		23d. Date of d Month	elivery Day Year
s, P.O.	signed b	d by P	Part II. Other significant conditions contributing to death but not res					bacco use contribute t	o the cause of death?
Division of Vital Records, P.O. Box Total Presented or Attending Physician: The law requires that the death	te has beer age 2 shou	omplete	Chronic Obstructive	e Lo	ung D	isease	24a. Was a autop: perfor 1 Yes	sy prior to med2 death?	utopsy findings available completion of cause of
ital F	certifica rector, p	Be	25. Was case referred to medical examiner?		Oth	ace of Death (Chec	k only one)	/	
of V	fter this	ate: To	1	R/Outpatient 28b. Time of injury	28c. Injury	4 □ Nursing H y at		ence 6 Other (Spe ow injury occurred	cify)
rision	er death. rector: A by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At ho building, etc. (Specify		M 1 □	Yes 2 No	28f. Location (St City or Town	reet and Number or R	ural Route Number,
Div	within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Scertifying Physician: To the best of my knowl	ledge, death or	ccured at the time	, date and place, a	nd due to the cau	se(s) and manner as s	tated.
To the H	within 24 To the Fi		only one) 3 Certifying Nurse Practioner: To the best of my	y knowledge, de	eath occurred at th	e time, date and pla	ce, and due to the	cause(s) and manner a	s stated.
	ŋ		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item CAWAYA SUPERIOR ST. St. Registrar's Signat	23a) (Tuna D	D3	58750	0 1	April 5	, 2011
	4		Edward Servel MD 5	60/10	ch Rave	n, Balo	timore,	Mar y land	1 21239
	Stat Registra	-	31. APR 12 201 (Par) Server 32. Registrar's Strat	Che !					

11-02734	
Priscilla Smith	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

riscilla Smith		State of Maryland / Department of Health and Mental Hyglene 1- For State Registrar Certificate of Death Reg. No.	135
Physicia	-	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year April 9, 2011 3. Time of De	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 7 / 1 / 54 Foreign M Country	or
nd show any ace.		Usual Residence of Decedent 10a. State N/A 10b. County 10d. Inside County N/A Baltimore 10d. Inside County Yes	
eath with the Maryland ritems 23a or 28a-f show ust be notified at once.	Director	10e. Street and Number 3812 W. Coldspring Lane 10f. Zip Code 21215 10g. Citizen of What Country? USA	
~ * 8	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No 1 Yes 2 N	ack,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic evect, the Medical Examiner.	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) Crossing Guard City Of Balt	
215-0 be filed wi mtal Hygie urked other cot, the M	å	17. Father's Name (First, Middle, Last) Johnny Smith 18. Mother's Name (First, Middle, Maiden Surname) Jestine Smith	
MD 21 2 should h and Me 27 is ma imatic c	ို	19a. Informant's Name/Relationship (Type, Print) Tamika Thomas/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3812 W. Coldspring Ln, Balt., MD 21215	
MOTE, Pages I and bent of Health unt: If item or other trau		20a. Method of Disposition 1	
Balti permit. Departri Imports		21. Signature of Funeral Price Linese 22. Name and Address of FacilityHari P. Close F. Svs. PA 5126 Belair Rd, Balt., MD 21206-5105	
Physician /Medical		23a. Part Effer the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease	Inset and
<i>£</i> xaminer <i>∀</i>		or condition resulting in death) Due to (or as a consequence of):	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of):	
50, te be executed sysician and burial - transit	EX-	d.	
760, cate be ex physiciar	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Box 6876 e death certificate the attending phy ed for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 1 Yes 2 No 9 V Unknown 1 Unknown 1 Unknown	Year
P.O. I res that the signed by the be detached	- 1	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V U	
Records, P.O. Box 68760, The law requires that the death certificate be ficate has been signed by the attending physici, page 2 should be detached for use as the burit,	Completed by	24a. Was an autopsy findings prior to completion of compl	
— <u>₩</u>	å	25. Was case referred to medical examiner? 1 V Yes 2 No 1	
C # . ` 4	ion: To	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	
Division To the Hospital or Atteodit within 24 hours after death. To the Fuoeral Director: A completely filled in by the fi	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Numor Town, State)	nber, City
To the Hosp within 24 ho To the Fuoc completely fi	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
D F 3 F 3	¥	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) April 10, 2011)
0	ŀ	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death / Month. Jr Physician William Smith 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) June 30,1945 Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1x M 2 □ F Pennsylvania 197-34-7857 65 Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-รี ระกดพ 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Balto. Perry Hall Md. 10e. Street and Number 10f, Zip-Code 10g. Citizen of What Country? 11 Kings Place 21128 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No

1 Yes, Give 106 / Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No <u></u> Year or Dates: 1964-1967 White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Co. Truck Driver 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William P. Smith, Sr. Mary Hanratty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Kings Place Perry Hall, Md. 21128 Bernadine Smith Spoude 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H.
Important. If Iter
any injury or oth 1 Burial 2 XCremation 3 Removal from State Atlantic Crematory 4-14-2011 Glen Burnie, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVD long standing Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and I for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for Pregnant at time of death 5 Other (specify) 2 □ No 9 Unknown the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> 2 No 3 Probably 4 Unknown 1 Tyes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2 No 2 🗌 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 2 🗌 No 2 ER/Outpatient 3 DOA 1 Yes 2 N 1 \square Inpatient 6 Other (Specify) 2 Director: After this filled in by the funeral 28b. Time of 27. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural cident 5 Pending investigation 1 Yes 2 No death. Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number. after (4 Homicide City or Town, State) hours a To the Hospital within 24 hours To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D-0061115 April 7, 2011

Registrar DHMH 17 Rev 1/2001 11595

State

4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pantle,

32. Registrar's Signature

A.

Hardin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9 8:08A Apri1 Medical <u>Diane Frances Smith</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balto. Overlea 516 Elmwood Road If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Social Security Numbe 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 □ M 2 **X** F Months Director 59 December 217-56-7975 Usual Residence of Decedent mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland attented to Heatth and Mental Hygiene. outant: If item 27 is marked other than "natural", or items 23a or 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Md Balto. Overlea 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 21206 516 Elmwood Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 ANo Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Bar Tending Bartender Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Vivian Cox Charles Johns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Overlea, Md. 21206 Wayne Smith Spouse 516 Elmwood Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith 4-13-2011 Balto. Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home <u>9705 Belair Road</u> Nottingham, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Int Between Onset od Death Immediate Cause (Final disease or condition non smallcell was cance Physician/ netusatie Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transii that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has the continuation of the continuatio autopsy performed? 1 Yes 2 No 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? ျ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined e Funeral L Medical 29a. Certifie 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OGUNDR. SLINE 302 TOWSON MD 21204 595 115/10 31. Date filed (Month, Day, 32. Registrar's Signature State Jack Registrar DHMH 17 Rev 7/2009

ANE

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 910 SANDERS 2011 /Medical City, Town, or Location of Death 4c. County of Death (If not institution, give street and number Examiner Baltimore wtheran Nursing Home 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. ast birthday) **Funeral** 1 ☐ M 2 🕶 F **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County or items 23a or 28a-f show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If lean 23a or 28a-f show limportant: If lean 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Medical Examiner must be notified an MD Yes 2 □ No altimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21216 Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🌠o Specify ⋛ 3 Midowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DOT DOT use relired) 15. Decedent's Education (Specify only highest grade completed) Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle Famer's Name (First, Middle, Last) Be ဂ္ or Rural Route Number, City or Town, State, 19a: Informant's Name/Relationship 2808 SOU 1216 panders MU Place of Disposition cametery, cremator 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the shock, or heart 1 isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest illure. List only one gause on each line. Immediate Cause (Final ATHEROSLIE ROTIL EREBRO VASCULA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) s been signed by the s should be detached t ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 2 □No 1 ☐ Yes 2. No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this eral Director: After thi filled in by the funeral 27. Maprier of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) neeu 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTO 2835 HIIME 31. Date filed (Month, Day, Year) APR 1 2 2011 32. Registrar's Signat State Registrar

		amend #5,12,206 Per Ph G914 4/15/2011 The State of Maryland / Department of Health and N	Mental Hydis	ne Legible.					
		1 - For State Registrar Certificate of Death		.No2011 11739					
Physic /Med		1. Depetient's Name (First, Middle, Last) Cherrelle Kenée Smith	2. Date of Death Month	Day Year 3:45 PM					
Exam	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ACRES ACRES	14 _{ps}	4c. County of Death					
Funera Directo		5. Social Security Number 44 6. Sex 214-11-6889 1 M 212 F 42 Yrs. Trunder 1 Year If Under 24 Hrs. Months Days Hours Min. Usual Residence of Decedent	8. Date of Birth (Month Day, Y	9. Birthplace (State or Foreign Country)					
ryland how		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits					
the Ma 28a-f s	ecto	MD 10e. Street and Number 10f. Zip Code	100	1 Wes 2 No . Citizen of What Country?					
th with 23a or	al Di	1105 Newfield 21207		USA					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examination to confined at more.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Warried 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black					
5-0	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work		b. Kind of Business/Industry					
21215-0036 d within 72 hours aft giene er than "natural" or	Completed by	Elementary/Sacopolary (0-12) College (1-4or 5+) Supply Technicia	in	FBI					
and 2 d be filed a ental Hygicked other	To Be C		e (First, Middle, Ma	iden Surname)					
Maryland to 2 should be file th and Mental Hy to 3 marked oth	-	19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rur	_						
ore, Notes 1 and of Health fitem 27		20a. Method of Disposition 20b. Place of Disposition (Name of		c. Location - City or Town, State					
Pa Pa		4 Donation 5 Other (Specify) Woodlawn Cemetery 4-19	1-2011	saltimore, onD					
Balti permit. Departi Importa any inja		21. Signature of Funeral Gervice Licenses 22. Navy Agrees (15 Co Co 5151 Balto. Na	t'I Pike	ral Services (21229)					
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, fairly, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		t, Approximate interval Between Onset and Death					
760, te be exergistion a pysician a ne burial-	cal	resulting in death) Last Due to (or as a consequence of):							
O. Box 68 he death certifica the attending ph	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) Unknown 5 Other (specify) Contact 1 Diversity 1		23d. Date of delivery Month Day Year					
ds, P, lires that the signed by d be detact	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death?					
Records, the law requires the has been signed age 2 should be or				2 No 3 Probably 4 Unknown					
Vital Rec sician: The law certificate has b irector, page 2 s	Completed		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? 9No 1 Yes 2 No					
of Vital Physician: T	Be c	examiner?	th (Check only one)	and C T Other (Const. 1/4.)					
on of ding Phys	on: To	27. Manner of D ath 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how	ce 6 Other (Specify) injury occurred					
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.							
To the within: To the comple	Mec	29h Signature and title of cartifier 29c License number	290	d. Date signed (Month, Day, Year)					
-1	8	1 K. Chur- Merson MD 5006010	PS A	pricy 2091					
61		30. Name and address for irson who completed cause of death (Item 23a) (Type, Print) K. M. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. M. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. M. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. M. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. M. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. M. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. M. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. M. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. M. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. M. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. M. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. M. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. M. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. M. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. M. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. S. Fried Completed Cause of death (Item 23a) (Type, Print) K. S. Fried Completed Cause of death (Item 23a) (Type, Print)	/saus	BALTIMORE (MI)					
St Regis	ate rar	31. Date filed (Monith, Day, Year) APR 12 2011 32. Figistrac's Signature							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 04 O8 20 T Nathan N. Stewart /Medical avn 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Courtland Garden Nursing Home Pikesville Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ XM 2 □ F 219-28-2756 11 Director 26 78 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norifled to once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NΔ 1 X Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. Funeral 3123 Milford Ave 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas & Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Electric Company <u>Mechanic</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown ပ္ Mary Jane Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hassan Rasheed-Nephew 3123 Milford Ave, Baltimore, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State t ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 4/15/2011 Owings Mills, Md 21. Si n ture of Funeral Service Licens 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Pa.rl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm diate Cause (Final acciden **Physician** isease or condition resulting in death) 6 mora /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician The law requires that the death certificate be by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has perform certificate ector. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Yes 2 | No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? within 24 hours after death. To the Funeral Director: After 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, -Day, - Year)

gistrar's Signature

W Be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1 Decedent's Name (First Middle Last 2. Date of Death 3. Time of Death Month Day **Physician** A M 2011 /Medical 4c. County of Death Facility Name (Lt, not institution, give street and number) 4b. City, Town, or Location of Death Examiner KAVEN CLC Da Ct, mo Re If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/22/1948 Birthplace (State or Foreign Country) 7 Age (In vrs last hirthday) **Funeral** Months Days Hours Min 62 Yrs. Director MD Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show MD Worcester Ocean City 1⊠Yes 2□No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 10332 Oxford Road 21842 by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No Navy
If Yes, Give 196-69
Year or Dates: hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ∐Yes 2 XNo Specify. Specif White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation filed within 72 I (Give kind of work done during most of working life, DO NOT use retired) d 2 should be filed within the and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Iron Worker 12 17. Father's Name (First, Middle, Last)
Charles Roy Simms 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Piesinger ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10332 Oxford Road, Ocean City, MD Health a Jason D. Simms / Son permit. Pages 1 and Department of Health. Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Final Journey crem. 4/11/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota, Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD Leastral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) letastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any least 1. Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) physician the burial Box 68760. Physician/Medical as IF FEMALE: nse 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 🗆 No 1 □ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Manner of eath Hospital: Other: Mac Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After this funeral of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Division Hospital or Attending Natural 5 Pending investigation ours after death. neral Director; Af filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital c within 24 hours at To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wes 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Raymond E.Shanklin Jr. Day Physician/ 7:30a M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore White Hall 4561 Shanklin Drive al Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) (Month, Day, 08/17/ Days 217-34-5012 Hours Min. 1 XM 2 □ F 72 MD **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State MD Baltimore 10c. City, Town or Location 10d. Inside City Limits e filed within 72 hours after death with the Maryland Director White Hall 1 Yes 21 No 10f. Zip Code 21161 10g. Citizen of What Country? 10e. Street and Number 4561 Shanklin Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married Completed by 1X Yes 2 □ No Army If Yes, Give Maryland 21215-0036 White 1 Yes 2 No Specify. Specify: "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important; If item 27 is no arked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Service Fireman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Birdie Smith Raymond Shanklin Sr. ပ 19a. Informant's Name/Relationship (Type, Print)
Gretchen E. Shanklin/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4561 Shanklin Drive, White Hall, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cemetery crematory or other place)
Final Journey crem. 4/9/2011 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services Poroța Marshall Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events are little death). Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been sinned by the attending hybridization and burial-transit the attending physician and hed for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death After this certificate has been signed by the an inneral director, page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death. Director: After this certificate has I autopsy death? 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🖾 No Hospital Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature 29c. License number 29d. Date signed (Month. \x\ 0431 30. Name and address of person with mpleted cause of death (Item 23a) (Type, Print) 3346 Date filed (Month, Day, strar's Signature

Registrar

APR 1 2 2011

DHMH 17 Rev 1/2001

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Damer Han		1- For State Registrar	State	O I Wai yiai lu /	•	cate of D		IIQ IVICII	ıtarı iygi		g. No.		
Physicia	n/	Decedent's Nam	ne (First, Middle,La	st)						Date of Deatl	,		3. Time of Death
Medical Examin	ier	Daniel		Tran					A	pril 7, 20	11		0012 hrs
			if not institution, gi lland Avenue	ve street and number)			anham	or Location of	of Death		4c. County of Prince Ge		
Funeral Director		5. Social Security P 225-21- (Unlw)	3539		(In yrs. last b ∔6	**	Under 1 Ye				20,1964		
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aryland	Director	10e. Street and Nu	O			10	f. Zip Code			10	g. Citizen of What	Cour	
th the M 23a or 2			Montague					2203			United		
Limore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Marri	ied 2 Marrie	1 Yes 2 v	ver in U.S.	If Yes, s	specify Cuba	an, Mexican,	gin? (Specify , Puerto Rica		White, e	etc.	can Indian, Black,
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6. 72 hou	Completed	Elementary/Seco		College (1-4 or 5+		during most o	of working lif			40110			•
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medica	E O	17. Father's Name	(First Middle Las			raint	eı	18 Mother	's Name (Firs	st Middle M	laiden Surname)	рго	ovements
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b 21 should nd Me	의	19a. Informant's Na	ame/Relationship (nam / Sis	• • • • • • • • • • • • • • • • • • • •	1						ber, City or Town,		
e, Misand 2 : Health 2 : item 27	ŀ	20a. Method of Dis	position			of Disposition	(Name of c	-	Da Da		20c. Location - Ci		
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite injury or other tr		4 Donation 5	Other Specify		Ches	atory or other p apeake	Crema	-	4/11/		Beltsv	_	le, MD
	1	21 Signature of Fu	Lom			933	Gist .	Ave.,	Silve	r Spri	n Service Ing, MD	20	0910
Physician /Medical	1		ne disease, or com lly one cause on e				•	g, such as ca	ardiac or resp	piratory arre	st, shock, or heart		Approximate Interval Between Onset and Death
Examiner		Immediate Cause (or condition resulting		Due to (or as a consequent		the Liv	er			-			Death
	ner	Sequentially list co if any, leading to in cause. Enter Unde	nmediate	Due to (or es a consequ	uence of):								
sit ed	Examiner	(Disease or injury to events resulting in	nat initiated death) Last	Due to (or as a consequ	uence of):							-	
A second	Medical	X UNPENDED	d	AMENDED 23a	pt.II	,27 per	me g	915 5	-4-11	vt			
Division of Vital Records, P.O. Box 68760, within 24 hours are dealt. The law requires that the death certificate be executed within 24 hours are dealt. The law requires that the death certificate be executed to the Funeral Nector. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transit.	Physician/Me	IF FEMALE: 23b. Was decedent past 12 months	7	23c. If yes, outcome 1 Live birth 4 Pregnant at tin		2 Fetal de	eath 3 (Specify)	Ectopic	pregnancy		23d. Date of de Month	_	ay Year
C. BC. the describe the strength of the streng	<u>~</u>	Part II. Other signi		9 Unknown	ut not resulti	ng in the under	lying cause	given in Par	rt I.	23e. Did tob	pacco use contribu	te to t	he cause of death?
ires that signed the detail	ğ	Chron	nic Alcoh							1 Yes	2 No 3	Proba	ably 4 🗹 Unknown
Vital Records, system: The law requirements his certificate has been a director, page 2 should	Completed								[24a. Was a autops perform	y prio	r to co	opsy findings available ompletion of cause of
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Vital hysician this cert	ğΙ	25. Was case referr examiner? 1 ✓ Yes ::		Hospital: 1 Inpatient	2 ER/0	Outpatient 3	DOA	1Othor	Check only of Nursing Ho		Residence 6 🗸	Other:	Scene
on of riding Phitt.	2 :::0	27. Manner of Death		28a. Date of Injury (Month, Day,Year	28b	. Time of Injury		ury at Work?		Describe ho	ow injury occurred		
Division of Vital Records, P.O. plate or Attending Physician: The law requires that the ours set death. The death incetor After this certificate has been signed by filled in by the functal director, page 2 should be deated.	Certification:	2 Accident 3 Suicide 4 Homicide	Investigat 6 Could not determine	be 28e. Place of Injury	y - At home,	farm, street, fac	ctory, office	building, etc		Location (St or Town, Sta		or Rur	al Route Number, City
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier 1		lan: To the best of my k									
To 1 Com	Medical	29b. Signature and		and manner stated.		- "		se number			29d. Date signed	_	
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Of sh		30. Name and addre Donna M. Vi		completed cause of dea Assistant Medical			nn Stree	t. Baltimo	ore, MD 2	1201			
Sta	te	31. Date filed mont		32. Registrar's	0 4			-, <u>-</u>		. = - 1	· -		
Registra	ar	ALIV	- LUII	part /	1								

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	1- For State Registrar	•	Cert	fificate of	Death		R	eg. No.	
Physician/ cal Examiner	1. Decedent's Name (First,		naniel		Taylor	Sr.	2. Date of Dea Month April 9, 20	Day Yea	3. Time of Death 1810 hrs
	4a. Facility Name (if not ins University Hospita		ımber)	4	b. City, Town, or L Baltimore	ocation of Deat	h	4c. County of	of Death
Funeral Director	5. Social Security Number	6. Sex	7. Age (In yrs. Ias 25		If Under 1 Year Months Days	If Under 24Hr Hours Min		th(MM/DD/YYYY)	9. Birthplace (State or Foreign MD
	212-13-793 Usual Residence of Decede 10a. State 10b. Co	nt		Yrs. Fown or Location					10d. Inside City Limits
nd show any ncc.	MD	NA		ltimor					1 Yes 2 No
the Maryland a or 28a-f show tified at once. Director	10e. Street and Number 5403 Jame	stowne Ct.	•		10f. Zip Code 2122	29	1	0g. Citizen of Wh	
r death with the rest of the r	11. Marital Status 1 X Never Married 2		cedent Ever in U.S orces? 2 X No	If Ye	Decedent of Hispans, specify Cuban, I	Mexican, Puert		White	- American Indian, Black, s, etc. Black
5-0036 led within 72 hours after itygiene. other than "natural", the Medical Examines Completed by	15 By and and Education	(Specify only highest grad	de completed)	16a. Decedent during mo	s Usual Occupation st of working life. If	on (Give kind of DO NOT use re		16b. Kind of Bu	siness/Industry
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than manatic event, the Medica TO Be Comple	Oliver N.	Taylor				Tanya	Ashe	Maiden Surname)	
MD 21 2 should 2 should 27 is man To	19a. Informant's Name/Rela			19b. Mailing 5403	Address (Street:	and Number or Owne C	Rural Route Nur	nber, City or Town timore,	n, State, Zip Code) Md 21229
Baltimore, MC pemit. Pages I and 2 si Department of Health an Important: If item 27 injury ar atther framms	20a. Method of Disposition 1 Burial 2 Cren 4 Donation 5 Oth			lace of Dispositematory or other		etery, 4/1	Date 2011 5/ 0211	Baltin	City or Town, State
Baltir permit. I Departm Imports injury m	21. Signatura of Funeral Se		huma-1	22. Na M a 4 3 0	ame and Address of F/H Waba			1	Md 21215
Physician /Medical	23a, Part I. Enter the diseas failure. List only one of Immediate Cause (Final dis	ause on each line.	aused the death. I		e mode of dying, s	uch as cardiac	or respiratory arr	est, shock, or hea	Approximate Interval Between Onset and Death
Examiner	or condition resulting in dea		consequence of)						
red nisit Examiner	if any, leading to immediate cause. Enter Underlying C (Disease or injury that initia	ause	consequence of)						
kecuted ceuted - transit - transit	events resulting in death)		consequence of)						
760, icate be executed sphysician and the burial - trans	UNPENDED IF FEMALE:	AMENDED 23c. If yes,	outcome of pregna	ancy				23d. Date of	delivery
	23b. Was decedent pregnar past 12 months?	I TIME	nant at time of dea		er (Specify)	Ectopic pregn	ancy	Month	Day Year
P.O. Bo. s that the de gned by the e detached f by Phy.	Part II. Other significant c	onditions contributing to	o death but not res	sulting in the ur	nderlying cause giv	ven in Part I.			bute to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box 68'. To the Hospital or Attending Physician: The law requires that the death certificate his the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as ledical Certification: To Be Completed by Physician.						· -	24a. Was autop perfo	osy p orm <u>ed</u> ? d	Vere autopsy findings available nor to completion of cause of leath? Yes 2 No
ital Recition: The secrificate irector, page	examiner?	Hospital:	Innatient 2 6	ER/Outpatient	<u></u>	of Death (Check		Residence 6	Other
Sion of Vi Attending Physis or death. Frectur: After this by the funeral difficult of the funera	1 Yes 2 No 27. Manner of Death 1 Natural 5	28a. Date	of Injury	28b. Time of In 1650 hrs	jury 28c. Injury			how injury occurr	
Division o Hospital or Attending: 24 hours after death. Funeral Directur: After redy filled in by the funeral Certification:	3 Suicide 6 4 Homicide	Could not be 28e. Place	e of Injury - At hor Barbershop	me, farm, stree	t, factory, office bu	ilding, etc.		Street and Number State) loga Street, Bal	er or Rural Route Number, City timore, MD
Di To the Hospital within 24 hours a To the Funeral I completely filled		ng Physician: To the best Examiner:On the basis and manner s	of examination an	e, death occurr d/or investigati	ed at the time, date on, in my opinion,	e and place, an death occurred	d due to the caus at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
	29b. Signature and title of o	ertifier - Pol () ale ~		29c, License O.C.M			April 10, 20	ed (Month, Day, Year)
3	30. Name and address of p Patricia Aronica-P		se of death (Item 2 ant Medical E		111 Penn Stre	eet, Baltimo	re, MD 2120	1	
State Registrar	(177)	(ear) 32.	egi str ar's Signatur	hay	وع				
DHMH 17 Rev 1/2001	nil)	OCME	was fi	ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Month Physician/ AM <u>Mildred</u> Teano Medical a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death tim Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 10, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🂢 F Months Days Hours ^{Year)} 1929 Maryland Director 213-26-7285 May Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified 1 ☐ Yes 2 🏋 No Maryland Baltimore Timonium 10e. Street and Numbe ò 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 512 Limerick Circle, Unit 204 21093 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or iter Examiner Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. "natural" Completed 3 Widowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ad with than Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>n</u>/a Own Home Homemaker Be 17. Father's Name (First, Middle, Last, of Health and Mental H fitem 27 is marked ot rother traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ပ Edmund Soter Cecilia Mohr Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health John Andrew Teano/Husband 512 Limerick Circle, Unit 204, Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4/11/11 Department of Important; If any injury or 4 Donation 5 Other (Speci Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. Enter the disease, or comp lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock or hear faili Immediate Cause (Final failure. List only of cause on Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): Examin attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 2 🗌 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tes မြ 1 Npatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death s after death. Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 29b. Signature and title of certified 29c. License number m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 2 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Truitt Jr. Day Physician/ Charles J. Month Year 04:45AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOS icomico lis Social Security Number 220-28-1266 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day 2/29/ 1 🔀 M 2 🗆 F 79 MD Director 1931 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director Salisbury MD Wicomico 1 XYes 2 No 10e. Street and Number 10g. Citizen of What Country? USA 21804 or items 23a Funeral 505 Bethel Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status 1x Yes 2 NoArmy
If Yes, Give 1952-54
Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Work Cleric 3 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gates Elizabeth charles Truitt Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 505 Bethel St., Salisbury, MD 21804Linda Ownby/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Termation 3 Removal from State Final Journey Crem. 4/14/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Services PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licenses Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ a. MALIGNANT PROSTATR GAR CINDUA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consuluence of and I-transit Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in by the funeral director, page 2 should be detached for use as the burn Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence HOSPICA 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. injury at 5 Pending 2 🗌 No Accident 1 Tyes Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier DO05 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 atturan BUP 733 31. Date filed (Month, Day, Year) State APR 12 2011 Registrar

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Ar

Certificate of Death

State of Maryland / Department of Health and Mental Hygie

2. Date of Death

_ 1 11 .	
e Legible. ne2011	11749
No.	
Day Year	3. Time of Death
2011 4c. County of Deat	9:45 A M
Somer	set
9. Birt	thplace (State or Foreign
	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Citizen of What Co USA	puntry?
14. Race - Ame Black, White	
Зресну.	hite
b. Kind of Business/	Industry
health	lcare
	1Ca1 E
den Surname) pence	
	Zin Code)
urg, MD	20878
c. Location - City or	
ooalion - City or	, Viaio
Baltimore	Street
,	Approximate Interval Between
	Onset and Death
1	
23d. Date of de	
Month	Day Year
cco use contribute t	to the cause of death?
2 □ No 3 □ F	Probably 4 Unknown
24h. Were a	autopsy findings available
prior to death?	completion of cause of
d? death? ¥No 1 ☐ Ye	
be 6 ☐ Other (Sp.	ecify)
injury occurred	
at	Princi S
et and Number or F State)	Rural Route Number,
se(s) and manner a	as stated. ue to the cause(s)
piaco, and dl	(0)

Physician /Medical Examine

1. Decedent's Name (First, Middle, Last)

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, I'm Marical Examinar man be refilled at any Injury or other traumatic event, I'm Marical Examinar man be refilled at appear.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ın al	WILLIAM HOMER	WILSON		April	5,	2011 9:45 A [™]
aı er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca		4c. Count	
-1	26270 B B Ctmoot		Crisf	516	Sc	omerset
	26378 F. Pear Street 5. Social Security Number 6. Sex 7. Ag	je (In yrs. last birthda	v) If Under 1 Year If U	nder 24 Hrs. 8. Date of B		9. Birthplace (State or Foreign
	1₩ 2□ F	83 Yrs.	Months Days Ho	urs Min. Dec 1	Birth Day, Year) 5, 1927	West Virginia
	336-38-2340	0.5				
	10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
_	Tod. State					1 □Yes 21☑No
cto	MD Somerset	Cri	sfield			
ire	10e. Street and Number		10f. Zip Code		10g. Citizen of	What Country?
글	26378 E. Pear Street			21817		USA
Jer	11 Marital Status 12. Was Decedent	Ever in U.S. 13	3. Was Decedent of Hispar	ic Origin? (Specify Yes or exican, Puerto Rican, etc.)	No- 14. Ra	ace - American Indian,
Ē	Armed Forces	No				ack, White, etc.
2	1 □ Never Married 2 □ Married 1 ▼ Yes 2 □ If Yes, Give 3 ▼ Widowed 4 □ Divorced Year or Dates:		1 □Yes 2🌠 No Sp	ecify:	Speci	ify: WILLE
ed	15. Decedent's Education	16a. Dec	cedent's Usual Occupation		16b. Kind of E	Business/Industry
et	(Specify only highest grade completed)	(Gi	ve kind of work done during e. DO NOT use retired)	most of working		
Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4or 1 2 4	5+)	physical the		he	ealthcare
ပိ	12			Mother's Name (First, Midd	lle. Maiden Surna	ime)
	17. Father's Name (First, Middle, Last)		10.	Claudia Pear		
မ	Leonard M. Wilson					
	19a. Informant's Name/Relationship (Type. Print)	19b. Ma	ailing Address (Street and I	lumber or Rural Route Nur k Lane Gaithe	nber, City or Towi	n, State, Zip Code) MD 20878
. 2	Michael Wilson/son	87	/ Still Cree	C Lane Galtin	ersburg,	TID 20070
	20a. Method of Disposition	l cometery c	sposition (Name of rematory or other place)	Date	20c. Location	- City or Town, State
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Cometery, Co	rematery of carer piaces			
	4 Donation 5 Other (Specify)		22. Name and Address of	Facility		
	21. Signature of Funeral Service Licensee Name Dir	ector		Facility Board 655	W. Balti	lmore Street
	KINN///KO-		Baltimore, N	ID 21201	, arreat	Approximate
	23a. Part). Enter the discrete shock, if heart failure. List only one cause on each l	d the death. Do not e ine.	enter the mode of dying, su	ch as cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	Pur	MONARY F	1BROSIS		
	regulting in death)	a consequence of):				
e	Sequentially list conditions, if any, leading to immediate Due to (or as	a consequence of):				
ni.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated country)					
xaı	triat illitiated events	a consequence of):				
a E						
ysician/Medical Examiner	d					
Me	IF FEMALE: 23c. If yes, outcome	o of programmy			204 5	Date of delivery
an/	23b. was decedent pregnant 1 Live birth	2 Fetal death	3 Ectopic pregnancy			Date of delivery Month Day Year
Sic	1 Yes 2 No 4 Pregnant	at time of death	5 Other (specify)		-	
Ě	9 Unknown			D. 11 220 D	id tabaaaa uga aa	entribute to the cause of death?
Ş	Part II. Other significant conditions contributing to death		e underlying cause given in			
b	ASCV	P		1	☐Yes 2☐No	3 ☐ Probably 4 ☑ Unknown
lete				24a. W		b. Were autopsy findings available
Ē				p	utopsy erformed?	prior to completion of cause of death?
Be Completed by Ph				1 □ Ye		1 ☐ Yes 2 ☐ No
	25. Was case referred to medical examiner? Hospital:		0.00	Place of Death (Check on		
2	12 res 2 100 1 1 Inpa	ient 2 ER/Outpa	itient 3 DOA	☐ Nursing Home 5 K F		
ü	27. Manner of Death 1 Natural 5 Pending 28a. Date of In (Month, D	jury 28b. Time <i>lay, Year)</i> Injur	ry Work?		be how injury occ	urreu
ati	2 Accident Investigation			2 □No		
ţįį	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of It building, €	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		n (Street and Nui Town, State)	mber or Rural Route Number,
Ser						
Medical Certification: To	29a. Certifier 1 Certifying Physician: To the bes	t of my knowledge, d	eath occurred at the time,	date and place, and due to	the cause(s) and	manner as stated.
dic	(Check only 2 Medical Examiner: On the basis and manners	stated.	mivesugation, in my opini	n, death occurred at the th	no, vate and plac	o, and due to the educe(s)
Me	29b. Signature and title of certifier		29c. License nu	mber	29d. Date sig	ned (Month, Day, Year)
	1 11	-6				1 5 2011
	30. Name and address of person who completed cause of	death (Item 22a) /Tu	D-48	098	Apri	1 5, 2011
	TOO. INCIDE AND AUDICOS OF DELSOIT WHO COMPLETED CAUSE OF	would (nome wa) (I)	pr == 1			

State Registrar Vijay Karumbunathan, M.D.

31. Date filed (Month, Day, Year)

- 201 Hall Highway - Crisfield, MD 21817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ADRI 19:55 **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 x M 2 . F 220-54-8984 59 May 17, 1951 Pennsylvania Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Ħ MD Catonsville 1 ☐ Yes 2x No Baltimore Director Examiner must be notified 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code death with or items 23a 14 Hay Pasture Court 21228 Funeral Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 Widowed 4 Divorced "natural". Completed permit. Pages 1 and 2 should be filed within 72 hr
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur
any Injury or other traumatic event, the Medical I
once. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5-1-Elementary/Secondary (0-12) Federal Government Chief Financial Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Dillon Irvin Frank Wolfe ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14 Hay Pasture Court; Catonsville, MD 21228 Lawrence V. Leibhart-Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Marriottsville, MD Crest Lawn Mem. Garden 4/12/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. signa ure of Funeral Service License Part Enter the disease, or complications that cased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List thily one cause on each line. MD 21228 1630 Edmondson Avenue; Catonsville, 23a. Part 4 Approximate Interval Between Onset and Death Immediate Cause (Final CARDE PULMONARY **Physician** disease or condition resulting in death) FRILLDRS /Medical Examiner CAROTAC ALREST Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner HEMORRHAGE nding physician and Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably 4 Unknown 1 T Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page 2 No 2 🗌 No 1 TYes 1 Yes certificate of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examine 1 Yes Hospital: 1 Impatient Other: 2 No 2 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 🗌 Residence 6 Other (Specify) မ this nin 24 hours after death.

the Funeral Director: After this nipletely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation Injury 1 Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. License numbe 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Registrar's Signat

600 North Wolfe St, Baltimore, MD, 21287

SOGNA

NEEL

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ am las Medical Examiner (if not institution, give street and number) Location of Death 4c. County of Death 7. Age (In vrs. last birthday) 8. Date of Birt 9. Birthplace (State or Foreign 24 Hrs. If Under **Funeral** 1 M M 2 🗆 F Min. 217-50-666 **Director** Usual Residence of Decedent or 28a-f shov 10b. County 10a. State filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☑ No Specify: 13/a 3 ₩idowed 4 Divorced "natural" other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Majden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If Item 27 is marked o any injuy or other traumatic eve once. မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Va Jahn 21. Signature of Funeral Service Licen ine Fundal Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset, and Death Immediate Cause (Final Physician/ Cardiopulmoner Arres disease or condition resulting in death) in hoomin Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit neumoni unknown that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Day Year 2 No To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached in 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k autopsy performe 2 No Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: မ 1 Tyes 1 Inpatient 2 FR/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 1 Secretifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 1 750293 8 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYCAND BALTIMONE, Con Se State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Mysth 421 Owen Wojick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth A(Month, Day, Year) 960 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 🕱 M 2 🗆 Maryrand 220-68-5904 50 Director Usual Residence of Decedent , or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Anne Arundel Millersville 1 🗌 Yes 2 🏻 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21108 8244 Elvaton Rd. United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc. 1 X Never Married 2 Married þ ☐Yes 2 🔀 No 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White If Yes, Give 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Transportation Freight Forwarder Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Wojick, Jr. Ramona J. (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Oak Lane, N.W., Glen Burnie, Maryland 21061 Marrian McCormick / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State $\mathtt{Apri}^{\mathtt{Date}} 1$ cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2011 Atlantic Crematory, Inc. Glen Burnie, Maryland 4 ☐ Donation Other (Specify) rkley-Ruddick Funeral Home, P.A. Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ umone disease or condition egatocellular (Medical resulting in death) Due to (or as a consequence of): Examiner 5 ale Supertially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown as been signed by 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy page perform death? 2 1 Yes Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No ပ 1 Tyes 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury work?
1 Yes 2 No s after death. M Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours a Medical 29a, Certifier 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type Burnie en 31. Date filed (Month, Day, Year) State Registrar

↓ DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APMRTL 8 Day 2011 Year 4:55a MARY M. WEISS Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTE TOWSON BALTIMORE 8. Date of Birth 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗶 F Months Days Hours Min (Month, Day, Year) 4/11/1915 95 **Director** 213-01-4716 MARYLAND Usual Residence of Decedent show 10a. State 10d. Inside City Limits 10c. City. Town or Location with the Maryland must be notified at Director 28a-f 1 X Yes 2 No MD N/A BALTIMORE CITY 10e. Street and Number 10g. Citizen of What Country? ò 10f. Zip Code Funeral "natural", or items 23a 2000 HILLENWOOD ROAD 21239 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. à 1 Never Married 2 Married 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: WHITE Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12TH GRADE Be Maryland filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be LOUIS WILLINGER MARY RUTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau 9517 WALTHAM WOODS RD. BALTIMORE, MD 21234 RAYMOND O. WEISS. JR./SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State BALTIMORE, MD 4 Donation 5 Other (Specify) PARKWOOD CEMETERY 4/11/2011 21. Signature of Funeral Service Licensee MOO2 17 THE JOHNSON FUNERAL HOME, P.A. TOWSON. BLVD. 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physicano NEWWANI disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 b No jo Day Year Pregnant at time of death Month 5 Other (specify) been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has the lirector, page 2 s autopsy performe 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Tyes ျပ Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, by the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No after death Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined n 24 hours after e Funeral Dire eleted filled in b City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one d title of sertifier 29b. Signature a 29c. License number Jours Duys Do 1447 April 8, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. J. 9+#201 B. Home 21204 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ Winchester P M Francis April 2011 5:00 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 7901 Gough Street Dundalk 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours (Month, Day, Yea 1 □**X**M 2 □ F Director 421-16-6248 89 New Mexico Usual Residence of Decedent or 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Dundalk 1 Yes 2 XNo Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21224 USA 7901 Gough Street 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Maintanence Person Continental Can item 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sidney Winchester Anastasia Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen S. Burns Daughter 7901 Gough Street, Dundalk, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Aprilate13, 1 XBurial 2 Cremation 3 Removal from State Owings Mills, MD. injury o 4 Donation 5 Other (Specify) 2011 Garrison Forest VA gn Ture of Funeral Service License ^{22. Name and Address of Facility} Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a, Part 1. Enter the disease, complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List Interval Between Immediate Cause (Final On et and Death ongestive Heart Physician/ disease or condition loyears Medical resulting in death) Examiner uears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
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1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes 2 No 1 Tyes Hospital or Attending Physician; ⁷ 24 hours after death. Funeral Director: After this certifica Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🗆 Yes 2 🗷 No ရ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number april 11, 2011 D 51185 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Internal Medicine Offices, Bultimore, MD Christmas MD 4940 Eastern Avenue, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 7 Month **Physician** Joseph Edward Yelski /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Hartord Bel Air Lorien Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/27/1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☑ M 2 ☐ F 92 212-09-4485 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State rat", or items 23a or 28a-f show Examiner must be notified at XXYes 2 □ No Director N/A Baltimore Maryland death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21231 2203 Eastern Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iter 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Repairman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Wancowicz Joseph Jelski ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1435 Bolton Street Baltimore, Maryland 21217 Karen Ritgert - Niece item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
Saint Stanislaus 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/13/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 21. Signature of Funeral Service Licensee complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death 23a. Part I. Enter the dis-Immediate Cause (Final Physician LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine ohysician and the burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760. or Attending Physician: The law requires that the death certificate be Completed by Physician/Medical certificate has been signed by the attending prector, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, LUNG DISTASE OBSTRUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ATRIAL FIBRILLATION HYPERTENSION autopsy performed ANEMIA 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ASSISTED Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred CIVING 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide (Eartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 6225. UNION AVE, HOVRE DE GRACE MO 21078

Registrar DHMH 17 Rev 1/2001

State

SURESH DHANJANI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2011 6:36 A Liyun Wu Yeh 9. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-51-5269 Months Days Hours (Month, Day, Country) 71 Director November 19 Taiwan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director or 28a-f sh 1 X Yes 2 ☐ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or Funeral 503 Beacon Hill Terrace 20878 Taiwan 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Asian 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Homemaker Own Home is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental 2 Lu Yeh Chowchi Hsui traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 27 12618 Lloydminster Drive, Gaithersburg, Department of Health Important: If item 27 any injury or other to once, Hengli Wu/ Daughter Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State April Montgomery Crematorium, 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 do M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hours disease or condition Acute Myocardial Infarction Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Jer Due to for as a consequence of Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending housing must burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Yes 2 X No cate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No Yes Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tyes 2 🔀 No Other: မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 😾 Natural 5 Pending 2 🗆 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D51980 April 9, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brett Gamma, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1825 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Co Baltimore 11more 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** Min. (Month, Day, Year) Country) Yrs. Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director 1 Yes 2 No 10g. Citizen of What Country? Funeral S. 2.7.2.444

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☐ Married ğ 1 ☐ Yes 2 If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. 3 ☑ Widowed 4 ☐ Divorced Black Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is marrany injury or other ပ inknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd Bul & ma. MillVale ames 507 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ne Pape 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Bull met 21244 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a. ATHISLOSCIENTIC CORPNARY BRYGRY disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Due to for as a consuluence of attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death been signed by the sahould be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown Records, 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy performed 1 ☐ Yes 2 ☐ No I ☐ Yes 2 🕶 this certificate After this certification funeral director, p Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: 2 No Other: မြ 1 \square Yes 1 Inpatient 2 FR/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending s after death.
I Director: Afted in by the fur Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Hospital Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) MCGANN 5401 OW COURT 31. Date filed (Month, Day, Year) 32. Registrar's Sig State APR 13 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death Month Physician/ 200 Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** timore Age (In yrs ast birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Director or 28a-f shov 10a. State 10d. Inside City Limits 10c. City, Town or Location death with the Maryland must be notified at **Funeral Director** 1 Ves 2 No TIMOR and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. other traumatic event, the Medical Examiner ò Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 ☐ Divorced "natural" 1ack 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Western Electric Be Father's Name (First, Middle, Last) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 20a. Method of Disposition Burial 2 Cremation 3 Removal from State permit. Page 1 a
Department of IImportant, If ite
any injury or ot
once. Donation 5 Other (Specify) 21. Signature of Funeral Savice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death S shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) piration Medical Due to (or s a consequence of): Examiner ha Sequentially list conditions, if any leading to him edictions. Enter Underlying Cause (Disease or linjury Examiner mentia that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be **B**ox 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No been signed by the atte should be detached for Month Year Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᅙ nsion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 1 Yes 2 No Yes 2 completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 124 hours after deat Prineral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the | within 2 To the | only one) 29b. Signature and title of cartifie 00062735 Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Raven Blvd MD 5601 onnau 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SOFIA ALEKSANDROVICH 08:15 AM 2011 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** N/A LEVINDALE HEBREW HOME BALTIMORE 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Country) 0270871928 1 M 2 2 RUSSIA Director 216-80-9198 83 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 No N/A BALTIMORE MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Funeral 21215 USA 3601 FORDS LANE, #418 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. WHITE 3 X Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ROSEWOOD STATE and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) NURSES AIDE HOSPITAL Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ GERSHBERG CLARA WEISENBERG ARON permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic of injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 48 MONTEVIDEO WAY, SAN RAFAEL, CA 94903 PETER ALEXANDER/SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State BETH TFILOH CEMETERY | 04/11/2011 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses Acatti 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final CIRRHOSIS Physician -IVER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examine Due to (or as a consequence of) Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) Pregnant at time of death Unknown the signed by t d be detach 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s nas autopsy performed? ial or Attending Physician: The la sa after death.

I Director: After this certificate ha ed in by the funeral director, page? 1 🗌 Yes 2 🗌 No Yes 2 🖸 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Hospital To the Hospital within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00064533 04-D8-2011 MYSICIAN LEVINDAZE CIERIATRIC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. BEWEDERE 3 SACTIMORE MIDZIZES MI 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month AUL 1:35 PM ANTHUN 2011 Medical 4a. Facility Name (if not institution, give street and numbe 4h City Town or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 10-06-1928 Director 114-20-7278 82 Usual Residence of Decedent f show should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6917 Rawhide Ridge U.S.A. 21046 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. or Completed by 1 Never Married 2 X Married X Yes 2 No Baltimore, Maryland 21215-0036 Air 1 Yes 2 X No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced White Force Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Colone1 U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Henry James Butler Gladys Field 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health ar tant: If item 27 is Mary A. Butler (Wife) 6917 Rawhide Ridge Columbia, MD 21046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Depertment of
Important: If it
any njury or o 1 X Burial 2 Cremation 3 Removal from State Lafayette Cemetery 4-16-2011 Lafayette, NY 4 Donation 5 Other (Specify) 21. Signatule of Funeral Service L 22. Name and Address of Facility Witzke Funeral Homes, obon 5555 Twin Knolls Road Columbia, MD 21045 23a. Part 1. Enter the diseale, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .Physician/ MYOCAKIIAL (NFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the bunal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by CAA)IOMYOAATHY Division of Vital Records, the Hospital or Attending Physician: The law requires 2No 3 Probably 4 Unknown 1 🗌 Yes Completed peen HYNER CHOLESTEROLE WIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed HYPERTENSION this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျာ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Deatl 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completed filled in by the funera 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical L Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10053051 address of person who completed cause of death (Item 23a) (Type, Print) General Hospital, 5755 Cedardane, Columbia, mo 31. Date filed (Month, Day, Year) State APR 1 3 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Month Year THOMAS BARTUN US :37 AM 2011 MPE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWAND COUNTY GON ARM www.20 INJSPITAL COLUMBIA If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🙀 M 2 🗆 F April 1 22 1955 New York Director 55 152-46-6024 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2x XNo Columbia Columbia Howard 10g. Citizen of What Country? 10e. Street and Number ō ms 23a or must be r Funeral U.S.A. 21045 5982 Jacobs Ladder within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or item ledical Examiner n 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Army 3 Divorced 4 Divorced White Completed Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) the Social Science Public Policy Researcher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Wright pe Frank Barton and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, MD 21045 5982 Jacobs Ladder (Wife) permit, Page 1 and 2 Department of Health Important: If item 27 any injury or other th Susan A. Lvnn Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Baltimore/Washington Crematory 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) 4-12-2011 Laurel, Maryland 21. Signature of uneral Servic License 22. Name and Address of Facility Witzke Funeral Homes, Inc. Columbia, Maryland 21045 MUIZ83 5555 Twin Knolls Road 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failu Interval Between Onset and Death Immediate Cause (Final disease or condition SEPTIL Physiciani SINOCK 2444 Medical resulting in death) Due to (or as a consequence of): Examiner BACTEREMIA 48 HG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 attending physical for use as the b IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death 2 No g Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, MUDINZIC CIPPHOSIE 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available 24a. Was an AMIFMIA autopsy performed? Yes 2 No prior to completion of cause of NJO (RATISTU MCVT8 1 Yes 2 No certificate Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **S**No 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 욘 this Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours at To the Funeral Di completed filled is Medical Nacertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 036974 APR 20 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q NO 21544 NYAWJUM MO 10710 CHANTER DR #310 WIUNGIA 32. Registrar's Signature State parked Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

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AMEND TTEM# 2 oper pHYS, G914, 4/13/2011, WS

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Apri1 Physician/ 5:15 PM Lula Bell Brown 0 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 806 Joshua Tree Ct. Ba1timore Owings Mills Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)

June 7, 1931 South Carolina 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X**X Hours 79 June Director 250-58-8561 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XXNo MD Baltimore Owings Mills 10e. Street and Number 10g. Citizen of What Country? ıral", or items 23a oı Examiner must be Funeral U.S.A. 806 Joshua Tree Ct. 21117 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes XX No þ ☐ Never Married 2 ☐ Married 21215-0036 1 Yes XX No Specify: Widowed 4 □ Divorced If Yes, Give Year or Dates Specify: Black "natural", Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper 12 Hospita1 Be Baltimore, Maryland filed 17. Father's Name (First, Middle, Last) unknown 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be nent of Health and Ments Modie Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 806 Joshua Tree Ct. Owings Mills, MD 21117 Norris Brown Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place)
All Faiths
Crematory & Chapel 1 Burial XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/18/11 Manchester, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Fineral Service Licenses 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician STAGE IVI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): physician Physician/Medical 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No been signed by the atte should be detached for Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 1 Yes 2 XNO 3 Probably 4 Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has 2 No certificate 1 Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence this within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 5 Pending Natural Accident 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

107

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April James A. Bordenski, Sr. 2011 6:38 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 2710 Merrick Way Abingdon 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex Funeral 1 🕅 M 2 🗆 F Months Hours Min (Month, Day, 216-24-1321 81 Yrs Balt. Director 1929 .Maryland eotember 6. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 V No Harford Maryland Abingdon ö 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? United States Funeral 23a 21009 2710 Merrick Way of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. or. þ 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married white 1 Yes 2XXNo Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Edward Renneburg and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Machinery Manufacturer & Sons Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental item 27 is marked ပ Joseph J. Bordenski Marie Koehler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21102 19a. Informant's Name/Relationship (Type, Print) Mrs. Roxanne Malbrough/daughter 5324 Carroll Warehime Road Lineboro, Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ott ApriBre 12, Cemetery, crematory or other place)
Dulaney Valler (Memorial Gardens Burial 2 Cremation 3 Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland of Juneral Service License Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093 Interval Between Onset and Death Physician/ one year Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical þe IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 Yes 2 No Yes -25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 or Attending Natural 5 Pending 2 No 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of perifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATNOOD RD #200 6025 BAHRANI m.D State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

09/89

Box (

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year :35 PM Physician/ Stella Briley MPril Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** University Baltimore 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Days Min. Months 1 🗆 M 2 🔀 F Hours 047237 Maryland 1948 62 212-54-9338 Director Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1x Yes 2 ☐ No Windsor Mill MD Baltimore Co. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21244 U.S.A. 20 Temons Ct. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than aumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 10th Grade Warehouse Packaging Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Louise V. Matthews Daniel T. Blackwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Shepley Ave., Baltimore, MD 21228 Bernice Thomas(sister) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) 1 🗌 Burial 2 🔀 Cremation 3 🗋 Removal from State on-site Crematory 04/14/11 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Forephaders of Brown Jr. Funeral Home PA umo 2140 N. Fulton Ave., Baltimore, Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ cancer disease or condition resulting in death) Breast Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death g Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been significant categories, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ☑ No 2 🗆 No within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director. 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Other: 2 V No 1 Inpatient 2 ER/Outpatient 3 DOA မြ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MSRajapatne M.D D0057-465 4 7/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD. 21209 Av. 5203 2835 Smith . S · Rajapakse, M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | | | 766

Margaret Conway Margaret Conway March 30, 2011 Year March 30, 2011	Od Inside City Limits 1 Yes 2 No Y? USA In Indian, Black, White
Enchantment of the Seas Cruise Ship Funeral Director Funeral Director Funeral Director Funeral Director N20 deg 46.8 min W067 deg 04.6 min Out-Of-State Social Security Number	Od Inside City Limits 1 Yes 2 No Y? USA In Indian, Black, White
Usual Residence of Decedent 10a. State PA Philadelphia 10b. County PA Philadelphia 10c. City, Town or Location Philadelphia 10c. City, Town or Location Philadelphia 10d. Zip Code 11d. Marital Status 11 Never Married 12 Was Decedent Ever in U.S. Armed Forces? 11 Never Married 12 Was Decedent Ever in U.S. Armed Forces? 11 Yes 12 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Never Married 12 Was Decedent Ever in U.S. Armed Forces? 11 Yes 12 Was Decedent Ever in U.S. Armed Forces? 12 Yes 13 Wes Decedent of Hispanic Origin? (Specify Yes or No- White, etc.) 14 Race - American White, etc.	Od Inside City Limits 1 Yes 2 No Y? USA In Indian, Black, White
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20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, part of place) 20c. Location - City or To crematory or other place) 4 Donation 5 Other Specify: 20c. Location - City or To crematory or other place) 4 Donation 5 Other Specify: 21. Streature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility 22c. Location - City or To crematory or other place) 4 Donation 5 Other Specify: 21. Streature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility 22c. Location - City or To crematory or other place) 4 Donation 5 Other Specify: 21. Streature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility 22c. Location - City or To crematory or other place) 4 Donation 5 Other Specify: 23c. Location - City or To crematory or other place) 4 Donation 5 Other Specify: 24. Streature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility 25. Streature of Funeral Home	PA
1501 E. Fort Ave, Baltimore MD 2	Inc. 21230 Approximate Interval
	Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse	
(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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24a. Was an autopsy performed? 1 Yes 2 No 1 Sec. 2	psy findings available mpletion of cause of
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25. Was case referred to medical examiner? 1 Ves 2 No 25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Manner of Death (Check only one) 28d. Describe how injury occurred (Month, Day, Year)	ocene
U in the state of	
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Specific to the cause (s) and manner as stated. Specific to the cause (s) and manner as stated. Specific to the cause (s) and manner as state	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month April 2, 2011	n, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	-
State 31. Date filed (Wonth, Day Year) 32. Registrar's Signature Registrar 3. Date filed (Wonth, Day Year) 32. Registrar's Signature	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Month Year **Physician** 8:37 AM Thelma D. Coates 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death **Examiner** Date of Birth (Month, Day, If Under 24 Hrs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2**X**F Baltimore, MD Director 215-28-5802 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Baltimore MD Baltimore 1 ☐Yes 2 ☐ No Director 10g. Citizen of What Country? Known as: Thelma Dlass Cat 10f. Zip Code Street and Number 3416 Redman Road USA 21207 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊟Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 🗷 No Baltimore, Maryland 21215-0036 Specify: Specify: Black ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any Injury or other traumatic event, the Medic once. Healthcare Elementary/Secondary (0-12) College (1-4or 5+) Nurse 17. Father's Name (First, Middle, Last)
Charles H.Ridgley, 18. Mother's Name (First, Middle, Maiden Surname)
Mary Virgina Smallwood ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathan C. Hale/Nephew 3416 Redman Road Baltimore, MD 21207 20b. Place of Disposition (Name of Gametery Stomotory Protections) 20c. Location - City or Town, State Date 20a. Method of Disposition 04-20-2011Owings Mills, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene 21. Signature of Funeral Service Licensee 8728 Liberty Road Randallston MD 21133 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or itear failure. List only one cause on each line. mmediate Cause (Final **Physician** Mybardia dow disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examine Division of Vital Records, P.O. Box 68760, 🦟 the Hospital or Attending Physician: The law requires that the death certificate be executed ettending physician and for use as the burlal-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1∐Yes 2 □No 9 Unknown been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 a autopsy performed 1 □Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day,

APR

Year)

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month James Cooper April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 2918 Windsor Avenue Baltimore If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 🔀 M 2 🗆 F 10/24/1934 **Director** 216-3407960 76 Usual Residence of Decedent show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10g, Citizen of What Country? Funeral 2725 Walbrook Avenue, Apt.207 21216 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces 1 Yes No If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Entrepreneur unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Willie Byum Marie Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Evans St., Glen Burnie, MD 21060 Sylvia Derrill (sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Calvary Cem. 04/08/2011Baltimore, MD Joseph H. Brown Jr. Funeral Home, P.A. 2140 N. Fulton Ave., Baltimore, MD 21217 21. Si nature of Funeral Service Licenses 236 Part 1. English the disease, or complications that caused the death. Do not enter the mode of dyin, shock, of heart failure. List only one cause on each line.

Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) **Examiner** Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) sician and burial-transit Cause (Disease or iinjury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year signed by the a 1 Yes 2 L 9 Unknown Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to e cause of death? Completed by Physician: The law requires 3 № Probably 4 🗆 Unknown 1 🗆 Yes 2 🗆 No Records, 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 ☐ No Yes Vita 25. Was case referred to med Be 26. Place of Death (Check only one) examiner? 1 Yes 2 ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home After this b 27 Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred AMES Hospital or Attending 1 D Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Atla

сотрleted filled in by the fun Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated State Registrar

H DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) \(\begin{align*}\) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NUNCY Month Year I Deitz 1331 April 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Northwest HOSP Center Randallstown If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** 5. Social Security Number 216-36-4057 9. Birthplace (State or Foreign 1 □ M 2 🗹 F Days Min. Country) Director 8-26-1938Malryland Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland notified MD Baltimore 1 Yes 2 No Windsor Mill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be Funeral 23a 1708 Hill Drive 21244 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces' Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Completed 3√ Widowed 4 Divorced Specify: Caucasian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Administrator Woodlawn Cemetery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental h ပ္ Roy Hale Katherine Mage and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trau 1708 Hill Drive Windsor Mill, MD 21244 Brenda Hayes/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park April 15,2011 Baltimore MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licens 22. Name and Address of Facility Vaughn C. Greene Liberty RD Randallstown, 8728 23a. Part 1. Engle the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician! Myscardia Awte Medical Due to (or as a consequence of) Examiner tens13 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Certificate: To Be Completed by Physician/Medical Examiner Du- to (or as a consequence of): attending physician and for use as the burial-transit iabetes Cause (Disease or linjury Ne that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 🗌 No Yes 2 No hours after death. Ineral Director: After this certifica of filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 X DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 1) 0065425 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CourtRd 401 012 32. Registrar's Sign

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day, Year)

APR 1 3 2011

Drummond 11-02255 Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day 2011 Medical Examiner 2155 hrs Andre Renard Drummond 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 514 E. North Avenue Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 212-86-8425 7. Age (In vrs. last birthday) **Funeral** 6. Sex Director Months Davs 12-9-1962 1[™]M 2□F Country) Yrs 48 Usual Residence of Decedent 10c. City, Town or Locetion 10d. Inside City Limits 1 X Yes 2 No or 28a-f sho Baltimore N/Amit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland porturent of Health and Mental Hygiene.

porturent: If item 27 is marked other than "natural", or items 23a or 23a-f she ury or other traumatic event, the Medical Examinary. ME 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 301 USA 21239 1651 E. Belvedere Ave. Apt. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes Black 3 Widowed 4 Divorced Yes, Give Yeer 1 Yes 2 X No specify: Specify: ੬ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Unknown 12th Unknown 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Thurmon Morgan Marlene Drummond 19a. Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1651 E. Belvedere Ave. Apt. 301 Balto, MD Marlene Hudley-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) 3/30/2011 Baltimore, MD Greenmount Cemt. 4 Donation 5 Other Specify: 21 Signature of Funeral Service License 22. Name and Address of Facility March F/H 1101 E. Ave. Baltimore, MD 21202 23a. Par I./Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and Medical a. Multiple Sharp Force Injuries Death xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burns after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Physician/Medical UNPENDED AMENDED#2perME,G914,4/13/2011,WS Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Piece of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Subject stabbed and cut FOUND: 5 Pending 1 Yes 2 V No Mar 22, 2011 2 Accident 2145 hrs Investigation 2Be. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 514 E. North Avenue, Baltimore, MD determined 4 Homicide (Specify) rowhome Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) one). and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 23, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Laron Locke MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registra 3

DHMH 17 Rev 1/2001 **OCME 2006**

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) AMONTH Physician 2027-M 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8, Date of Birth
Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 217-68-1884 Days 1 🗆 M 2 🗶 F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number Items 23a more Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No "natural", or Specify: If Yes, Give Year or Dates: ğ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specity only highest grade completed) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' any injury or other traumatic event, the Me College (1-4 or 5+) John pervisor s Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) 17. Father Be gene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto, MO 21213 evon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 4-11-2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March 21. Signature of Funeral Service Licenses MD 21202 Himore, 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown P.O. 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records, No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home 1 Inpatient 3 DOA 2 [2 ER/Outpatient 5 Residence 6 Other (Specify) 1 Yes မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 No 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and the cause(s) and the cause (s) and t Medical (check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 6,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sud. 600 North Wolfe St, Baltimore, MD, 21287 Saho 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) nonth. Physician/ MANUEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Northwest Seasons Hospice Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🖾 M 2 🗆 F Days 10-30-NC Director 218-36-252 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** NA Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Forest Park Avenue 21207 USA 4101 W. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 14. Race - American Indian, Black, White, etc. African Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: American If Yes, Give 3 Widowed 4 Divorced Be Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 10th Grade Home Improvement Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mannie Roseitta Dickens Dickens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4101 W. Forest Park Avenue Baltimore, MD Ruth Anderson-Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place)
Mt. Zion Cem. 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 04-18-11 Lansdowne, MD 4 Donation 5 Other (Specify) Wylie Funeral Home P.A. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ 11 Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital 1 Tes ٩ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No M Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Bural Boute Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie icense number ss of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type of State

or Print in Black indelible ink. Ensure All Copies Are Legiple.	I	7	7	0
e of Maryland / Department of Health and Mental Hygien	To the last	1	i	0

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Foster **Physician** Ann 29 2011 2045A M evry March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Dorchester Campridge Dorchester General HOSAItal If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthdav) Date of Birth (Month, Day, 6. Sex **Funeral** Year) Days Months Hours Min. 1 □ M 2 🖵 F 512-26-4251 79 Director 1/27/32 ARUsual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at TX Tarrant Fort Worth 1X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4908 Westlake Drive 76132 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 242/15-0036 If Yes, Give Year or Dates: 1 □Yes 2√□No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) US General Services 12 4 Regional Counsel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carl Tribble Catherine Neisler ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Josh Foster / Son 2328 Stadium Drive, Fort Worth TX 76109 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation → Removal from State Greenwood Mem. Park 4/2/11 Fort Worth, 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign the of Function P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Disease Immediate Cause (Final Atherosclerotic Coronary Vascular Un tenum **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dit Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) has it is a long to the least of person who completed cause of death (Item 23a) (Type, Print) has it is a long to the least of person who completed cause of death (Item 23a) (Type, Print) has it is a long to the least of person who completed cause of death (Item 23a) (Type, Print) has it is a long to the last of the las 10 31. Date filed (Month, Day, Year) State APR 1 3 2011 Registrar

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State of Maryland / Department of Health and Mental Hygien 🖒 Certificate of Death Dededent's Name (First, Moldle, Last, Date of Death 3. Time of Death Physician/ 12:00PM eming Medical **Examiner** Town, or Location of Death 4c. County of Death Baltimore (In yrs. last birthday) Yrs. If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min Director 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1timore MD 1 XYes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 ISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working ife: DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementa presenday (0-12) College (1-4 or 5+) Be (First, Middle, Lest) ပ္ e/Relationship ton Method of Disposition 20b. Place of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy rate has been signed by the atte page 2 should be detached for a in the past 12 months? Pregnant at time of death
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate 1 Yes 2 No Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this filled in by the funeral 27. Manner of Beath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Dav. Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month () Physician/ 03:28 AM garrisor cque Medical 4a. Facility Name (i) not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospita Agnes Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth Funeral 100-42-761 1 🗆 M 2 🔀 Months Hours Min. Country) Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director MD *Vindsor* 1 ☐ Yes 2 😘 o 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö iral", or items 23a o Examiner must be Funeral 21244 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Meany injury or other traumatic event, the Me Colege (1-4 or 5+) Elementary/Seconday (0-12) lurse Be 17. Father's Name (First, Middle ပ္ ourison 19a. Informant's Name/Relationship (Type, Print) (Sister) 19b. Mailing Address (Stree 01752 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, cremat or other place) 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dneumonia days disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Jacquelin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): been signed by the attending physician Physician/Medical P.O. Box 68760 for use as Garisons 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 4 Pregnant at time of death 9 Unknown 5 Other (specify) Day page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Sarcoidosis 2 No 3 Probably 4 Unknown Records, 1 Yes Completed restrictive lung disease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 has Kenal failure this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tyes 2 700 ျှ 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural Accident injury 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mingozi along, 2011 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ming-Hs: Wang 900 Caton Baltimore Ave. MD 32. Registrar's Signature State Registrar

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	State of Maryland / Department of Health and Mental Hygiene						ene			
Registrar 1. Decedent's Name (First, Middle, Last)				st)	Certificate of Death			Reg. No. e of Death 3 Time of Death		
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46	Funeral Director			□M2\$0F 81	Yrs. Month			rear) Co	thplace (State or Foreign buntry) Son, Georgia	
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	larylar 3a-fsl iffied	Director	Manda Mand	more	No. H	hinalan m			1 ☐ Yes 2 ☑ No	
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	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Funeral	4446 Kendi	Koad		21236		Inited	States	
(0	or iter	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.Armed Forces?1 ☐ Yes 2 ☐ No	S. 13. Was Dec	edent of Hispanic Origin? (S pecify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit		
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Baltimore	nit. Page 1 artment of ortant: If it injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Hemovar nom otate		nonal Park Apri	16,2011	Daltimor	e Maryland	
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	* 2 Sal 1	22. Name	and Address of Facility	apela Cren	nation Ser	VICES 1234	
			23a. Part 1. Enter the disease, or comp	olications that caused the deat	th. Do not enter the mo			rkuille M	Approximate	
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P.O.	The law requires that the death ate has been signed by the atte page 2 should be detached for		9 ☐ Unknown ` Part II. Other significant conditions co	ontributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did toba	acco use contribute to	co use contribute to the cause of death?	
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Sorc	2 15	Completed					24a. Was an autopsy		Itopsy findings available completion of cause of	
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of Vital Records,	sician: The certificate irector, pag	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	7 <u></u>	26. Place of Death (Che			Assisted	
of V	g Phys er this neral di	te: To	27. Manner of Death	28a. Date of injury	ER/Outpatient 3 28b. Time of	28c. Injury at	ome 5 ☐ Residen 28d. Describe how	ce 6 X Other (Specinium) occurred	city) Living	
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Division	after of Direct	Cert	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		ory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,	
_	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	(Check 2 \(\sum \) Medical Examin	cician: To the best of my know ner: On the basis of examination the Practioner: To the best of m	n and/or investigation, i	n my opinion, death occurred	at the time, date and	place, and due to the	cause(s) and manner stated.	
	To the within 2 То the сопре	_	20h Signature and title of certifier		2	9c. License number		d. Date signed (Mont		
			$\overline{}$	leham 1		D35100		April	8,2011	
_	le		30. Name and address of person who c	ompleted cause of death (Item	n 23a) (Type, Print)	Street Suite	102 Bell	male man	71701	
	Stat		31. Date filed (Month, Day, Year)	32 rasistrar s Signa	ture	THE SUITE	IUD VAITI	MO'C ITE		
	Registra	ır	APR 1 2 201	19 Arma	9 Market	V				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APR II HUGO GOLDBERGER 09 2011 07:30A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** COLUMBIA HARMONY HALI HOWARD If Under 1 Year 5. Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days 1 X M 2 - F Months Hours Min. 12/16/192 Country) 89 Yrs. **GERMANY Director** 213-28-5661 Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director MD 28a-f N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 6300 RED CEDAR PLACE, #405 21209 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after L Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Mentinal Examina δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) TECHNICIAN **ELECTRONICS** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, မ ERIC GOLDBERGER AUGUSTA SCHUHL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON WEINSTEIN/DAUGHTER 9716 RIVERSIDE CIRCLE, FILICOTT CITY. MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 **X** Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHEVRA AHAVAS CHESED 04/10/2011 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS. 21. Signature of Juneral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ thlersient disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): ending physician are as the burial-Physician/Medical requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day Year Pregnant at time of death signed by the a d be detached f Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 1 24 hours after death. • Funeral Director; After this certificate has b page 2 s autopsy performe 2 X No 1 Yes 25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: 1 Tes 2 No OCSSISTER ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the within To the 29b. Signature ind title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Cme and address of person who completed cause of death (Item 23a) (Type, Print) 100

State Registrar 31. Date filed (Month, Day, Year)

APR 1 3 2011

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :00 pm MARVIN GOLDBERG Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death mint Joseph Center Medical saltimore 0W50V If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Sex 1 X M 2 □ F 05/23/1939 Months Days Hours Min. Director 71 Yrs. NY 110-30-5191 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ☐ Yes 2 X No NJOCEANS JACKSON 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 514 MOORES COURT 08527 USA Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items important if item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner muonee. and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces? Black, White, etc. δ 1 Never Married 2 X Married 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ENGINEER CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JULIUS GOLDBERG ROSE WISHNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 514 MOORES COURT, JACKSON, NJ 08527 BARBARA GOLDBERG / WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place, 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/12/2011 ELMONT, NEW YORK of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician Due to (or as a consequence of) disease or condition resulting in death) Medical Examiner Sequentially list conditions cause. Enter Underlying Examir Cause (Disease or linjury that initiated events Post Renal Transplant burial-trar and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month Day Pregnant at time of death Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Severe Metabolic Acidosis Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Acute Renal Failure . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 D. No Other: မ 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) n 24 hours after death.

Refuneral Director: After the pleted filled in by the funeral funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of cert (Month, Day, Year) 29d. Date signed eted cause of death (Item 23a) (Type, Print) 15V 76010sler LOW, MID Date filed (Month, Day, Year Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ HOUSTON FREDERICK 6:35 PM 2011 A Paril 06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARBOR HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** CountyMary 1 M 2 F Months July 23 217-52-665 61 land Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Baltimore Maryland 1 Yes 2 No 10e. Street and Number Roun 10g. Citizen of What Country? 10f. Zip Code or items 23a Funeral Was Decement Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubas, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Examiner Black, White, etc 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 ☑ No Specify: Black If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. Private Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Edward Houston Evelyn 19b. Mailing Address (Street and Number or Rural Poute Number, permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Bushrad-sister Baltimo 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City of cemetery, crematory or other place; Garnson Forest Vet. Cem. 1 Burial 2 Cremation 3 Removal from State owings Mills, Mar 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses sta 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 days Immediate Cause (Final Physician/ (exebrogascular Accident disease or condition resulting in death) Acute Stroke Medical Due to (or as a consequence of **Examiner** days Tract Due to (or as a consequence of) Infection Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury days Deep Verous Thrombasi that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician a Physician/Medical death certificate be Box 68760 attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 4 Pregnant ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | þ Hypertension, Seizuse 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Disorder Completed 24b. Were autopsy findings available 24a. Was an Disease Coronan page 2 s prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy certificate Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 - No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 24 hours after death.
Funeral Director; After thi eted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Decertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Vasarada, MD April (06/2011 RES 001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 South Hanover Street. Baltimore, MD 21225 Vasavada Vishal 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jeffries 5:10a. 04 05 2011 Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Home Arlington West Nursing If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**□ M 2 □ F Months Days (Month, Day, Year) Hours Min. 227-34-6110 **Director** 80 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NA Baltimore 1 X Yes 2 □ No MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21216 1639 North Hilton Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) [Jkr Elementary/Seconday (0-12) Self Employed Home Improvement Be 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Unknown 21216 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md Maggie Thomas-Friend 1639 North Hilton Street, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, 4/15/2011 Carmel March H West 4300 Wabash Ave, Baltimore, Md 21215 Statury Funeral Service Licensee 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Pelvic Ostro myelitis 4/5 Medical Due to (or as a consequence of): Examiner Troclan if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal deat
Pregnant at time of death in the past 12 months?
1 Yes 2 No Month Day Year sate has been signed by the page 2 should be detached g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed 2 🗌 No Yes 2 N Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, examiner?

1 Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) M D 43386 04-08-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 N. Echa *405 toward 31. Date filed (Month, Day, 32. Registrar's Signature State APR 1 3 2011 Registrar

DHMH 17 Rev 7/2009

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Saac Jenkins 605 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE NA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 36 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 212 62 8133 Year) 1 M 2 □ F Months Days Hours Min. Director 195 Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Funeral Director MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3725 Edmondson Ave 21229 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aide 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adams Jenkins ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3725 Edmondson AVE. Jenkins-Balto Wife MO 20c. Location - City or Town, State Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Star Canday 4
22. Name and Address of Facility Catansville, mo 22. Name and Address of Facility

Coay P. March F.H. 270 Fredhillon Ro

23a. Part Epr the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate cluse (Final disease or condition resulting in death)

a. Hago Fredhilton Pass Balto. mo 21229 Approximate Interval Between Onset and Death Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an has autopsy After this certificate 2 P 1No Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 Avo 1 Nopatient 2 ER/Outpatient 3 DOA Certification: To ð 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division or Attending 1/DHNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Hospital 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title, of certified 29c. License number APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 90 CATON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			Please Type or Pri amend item 2 State of M	nt in Black	Indelible Ink g914 4–13–	Ensure A	II Copies	Are Legible.	11700		
	1 - State Registrar Certificate of Death					Reg. No.					
П	1. Decedent's Name (First, Middle, Last) Physician/ Madical Hilda Jackson						2. Date of Death	3. Time of Death			
, parenting	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	March	31 2011 4c. County of Deat	1:50 AM		
			Genesis Multimedical Cente			on, mary 1.		Baltim			
Funeral Director 5. Social Security Number 6. Sex 1 - Age (In yrs. last birthday) 1 - M 2 ■ F 7. Age (In yrs. last birthday) M M						If Under 24 Ars. Hours Min.	8. Date of Birth Month, Day	Year) 940 9. Bird	thplace (State or Foreign untry) Mary qual		
	nd show at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits		
	Maryla 28a-f s otified	Director	Maryland Baltimore		TOV	NSON			1 Ves 2 No		
	ith the 23a or st be n	ral D	10e. Stréet and Number 7706 York Rd		10f. Zip Code	21204	1	0g. Citizen of What Co	untry		
	death w	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?		. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ame			
936	s after oral", or	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	No	1 Yes 2 No		rilodii, Oto.,	Black, White Specify:	ack		
2-0	2 hours "natur edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupa e kind of work done du		ing	16b. Kind of Business	Industry		
2121	vithin 7 jiene. er than the Me		Elementary/Seconday (0-12) College (1-4 or 5	life	DO NOT use retired) Pves		1	by Cleaner	I		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) Calvin Coleman	•		18. Mother's Name	e (First, Middle, M	aiden Surname)			
Mary	12 should lith and M 27 is ma r traumal		19a. Informant's Name/Relationship (Type, Print) Rodney Brockington - Son	19b. Mai	iling Address (Street a	nd Number or Rue	Route N ber,	City or Town, State, Zip	cotie) 21215		
ore,	e 1 and of Hea If item or other		20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State	20b. Place of Disp cemetery, cre	position (Name of ematory or other place	e) [20c. Location - City or			
Baltimore,	nit. Pag artment ortant: injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Mt. Lar	22. Name and Addres	y 41	111	Landsdown	Maryland Home, PA		
Ba	Depar Impor any ir		Jen tak	W 3	3512 Freder	rick Ave	Baitin	vore Mar	Vand 21229		
Ι.	enorale w		23a. Part 1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final	e.				st,	Approximate Interval Between Onset and Death		
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	Examiner	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
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	e executed cian and ourial-transit			a consequence of):							
3760	ficate b g physi as the k	Medic	d								
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of del Month	livery Day Year		
P.O.	that the ned by detacl	by Ph	Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?		
rds,	een sig	ted k	End Stage Renal Disease				1 🗆 Ye	s 2 No 3 P	robably 4 Unknown		
eco	e law n e has b ge 2 sh	Completed	Pneumonia Clostridium difficile Colitis				24a. Was an autops: perform	y prior to oned? death?	topsy findings available completion of cause of		
<u> </u>	ian: Th ertificate ctor, pa	Be Co	25. Was case referred to medical		26. Pla	ce of Death (Check	1 Yes 2	P ≦ No 1 L Yes	s 2 1 No		
Ę	Physic this ce	မ	Hospital:	ent 2 ER/Outpatie		4 Mursing Ho		nce 6 Other (Spec	ify)		
o uo	anding sath. rr: After ne fune	ficate	27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 2 ☐ Accident Investigation M M 1 ☐ Yes 2 ☐ No								
Division of Vital Records,	tal or Atters as after de al Directo	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	ne Hospit in 24 hour ne Funera pleted fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of Medical Examiner: On the basis of example only one) 2 Medical Examiner: To the	xamination and/or inve	estigation, in my opinior	, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.		
						Od. Date signed (Month					
	3/31/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle E. Kalendek, CRNP Genesis Multimedical Center 7700 York Road Towson, Maryland 210 31 Date filed Month This Year!										
	3		MICHELLE . KOLENGEK, CRNP GENES 31. Date filed (Month, Day, Year)	Sis Multimer er's Signature	dical Center	-7700 York	Road To	wson, Mary	land 21204		
	Stat	_	ADD 1 0 2011	i s oignature							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Frances Irene Jordan April 7. 2011 6:00 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1136 Gloria Avenue Baltimore Arbutus Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Days Hours Sept. 22, 1 🗆 M 2 🕱 F Virginia Director Yrs 1922 212-20-5417 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Baltimore Arbutus 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1136 Gloria Avenue 21227 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Yes Yes, Give 2 XNo Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2x ☐ No Specify: White Specify: "natural", 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) f Health and Mental Hygiene. item 27 is marked other than ' other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Receptionist Medical Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Albert Lambert Bertha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) Gary Armentrout 5941 Cecil Ave., Blatimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jackson Cemetery 4/11/11 Mt. Jackson, VA 21. Signature of Funeral Service Literate 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a Paramer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician. Metastati(Neck disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner equentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No 1 Live Birth
4 Pregnant a
9 Unknown Day Year Pregnant at time of death this certificate has been signed by the all director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 Yes Division of Vital Be (25. Was case referred to medica funeral director. 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director, After th completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 No M Accident Investigation Suicide Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and addi ess of person who completed cause of death (Item 23a) (Type, Print) Chuice MEKAS 716

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienefor State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Veal MOVIO 2011 Medical 04 00 30 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Health Baltimore N/A Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign Days 1 XM 2 🗆 F Min 213-62-7013 53 0574771957 Maryland Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD N/A 1 XYes 2 No Baltimore 10e. Street and Number ŏ 10f. Zip Code 10g, Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral Smallwood St. 2111 N. 21216 .S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 1 V Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Divorced 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) 10th Grade (0-12) College (1-4 or 5+) Laborer unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked George Shanton Lucille Jones other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Shields(sister) 2111 Ν. Smallwood St., Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or 4 Donation 5 Other (Specify) on-site Crematory 04/12/11 Baltimore, MD Signature of Funeral Service Licensee ²²Josephorn of Brown Jr. 2140 N. Fulton Ave., Funeral Home PA Baltimore, MD 21217 any wino 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician ratu Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions Examiner if any leading to in med cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last $u \tau l$ attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 🕏 Probably 4 ☐ Unknown hronic Completed Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autopsy performed Yes 2 death? Yes 1 🗌 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ဨ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 124 hours after death.

Le Funeral Director: Al pleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ma y noout 31. Date filed (Month, Year APR 1 3 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Reg. No. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1/47M 201 N IN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 **X** M 2 □ F Vrs 66 218-44-9774 08/31/1944 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

Int; If Item 27 is marked other than "natural", or Items 23a or 28a-f show iry or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10h Counts 10c. City, Town or Location 1 X Yes 2 ☐ No Director MD Baltimore Dundalk 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral 2707 Page Drive 21222 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) . 10 Clothing Cutter Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tarntler ည George Kaline Evelvn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; if Item 27 is
any Injury or other trau Stephanie Hurley / Daughter <u>2707 Page Drive, Dundalk, MD 21222</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 04/12/2011 | Hanover, Maryland Anatomy Gifts Registry 21. Signature of Fatheral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 🗌 No the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 Unknown 1 TYes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has perform 1 Yes certificate Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 \square Nursing Home 2XER/Outpatient 3 DOA 2 □ No 1 Inpatient 5 Residence 6 Other (Specify) ပ္ 1 Yes this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Certification: after death.

Director: After the in by the funera (Month, Day or Attending 5 Pending investigation Natural ☐ Accident 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, completely filled in by 4 Homicide City or Town, State) e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in the state of the cause o Hospital 29a. Certifie Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2 23540 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

APR 1 3 2011

Dr. Hugh Hill

31. Date filed (Month, Day, Year)

32. Registrar's Signature

4940 Eastern Avenue, Baltimore, MD, 21224

ORIGINAL

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 1 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ Eleanor M. Kreis April 8. 10:58 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 343 Whitfield Road Baltimore Catonsville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) ug. 5, 1923 1 □ M 2 🏻 F Days Hours 217-18-0207 87 Maryland Vrs Director Aug. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at 10d. Inside City Limits Director 28a-f Baltimore MD Catonsville 1 Yes 2 🔽 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 343 Whitfield Road 21228 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thai any injury or other traumatic event, the Merian injury or other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 John E. Morse Grace Zell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lou Kreis Daughter Clairidge Road; Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Date unk 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 7/11/11 Sterling Ashton Schwab Witzke Catonsville, Inc. Avenue: Catonsville, MD 21228 22. Name and Address of Facility Sterl: Funeral Home of Catons 1630 Edmondson Avenue: Signature of Euneral Service icense MOIDS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Due to (or as a consequance of) END disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Jause (Disease or iinjury the attending physician and the for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year P.O. sate has been signed by a page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 2 director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 KNO 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nerse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 34951 1Car 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jude 100 Comonille us 2020 EDMWND 31. Date filed (Month, Day, Year) Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Month Physician/ 10 05 AM LOUE 2011 04 Medical Facility Name (if not institution, give street and number 4b. City Town, or Location of Death 4c. County of Death **Examiner** BALLIMORE 1 6 N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) Funeral **™**M 2 □ F Months Days Hours Min. April 7 1923 South Carolina **Director** 250-20-5330 87 Usual Residence of Decedent 28a-f shov 10b. County aţ 10a State 10c. City, Town or Location 10d. Inside City Limits Director item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified 1 Yes 2 ☐ No Baltimore <u>Maryland</u> N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 USA 2009 E. 32nd Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: If Yes, Give Year or Dates Specify:Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 8th grade Crane Operator Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Moranda Conwell John Lovely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2009 E. 32nd Street Baltimore,MD 21218 Catherine Lovely/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 4-15-2011 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charman - Harris Funeral Home 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No the a 9 Unknown 9 I Inknown signed by till Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page performed death? 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 1 No 1 Tyes မ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending work? Matural injury 5 Pending 2 No Accident Investigation Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature completed cause 30. Name and address of person who 5 31. Date filed (Month, Day, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1410PM CHARLES APRIL 00 2011 TTLE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** N/A if Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 239-74-5902 1**X** M 2 □ F 66 Yrs. **Director** 2/9/1945 N.C Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits ms 23a or 28a-f show must be notified at 1 Yes 2 □ No Director N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 808 N. Curley Street 21205 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married 6 1 ☐ Yes 2 X No Specify: Specify: Black þ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry Medical 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Underground linesman 12th BG & E ulth and Mental Hygid 27 Is marked other r traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Alexander Little Bella Bowden 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is any injury or other trains Tarsha Little-Daughter 808 N. Curley Baltimore, MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Snowhill 4/17/2011 Mt. Gilead, NC 21. Signature of Funeral Service Lice 22. Name and Address of Facility March F/H 1101 North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RESPIRATORY Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CARDIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed DIAL NONISCITEMIC for use as the burial-trar Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 No funeral director, page 2 should be detached P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 No 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital: 1 Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury s after death. 1 Yes 2 No 2 Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours a To the Funeral D 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 MOTHY 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 11595

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Elizabeth A. Lancel Otta Day D **9** Apri Dilo 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner University of Maryland Methcal Center Baltimore 5. Social Security Number 213-05-3428 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**□ F Months Days Hours Min 92 Director <u>Maryland</u> Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 XNo MD Howard Ellicott City 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 2600 McKenzie Road 21042 U.S.A. 12. Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: White 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward J. Welsh Ellen McGary permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores A. Wilkie, Daughter High Stepper Trail: Sykesyille, MD 21784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State St. John's Cemetery 04-11-2011 □ Donation 5 □ Other (Specify) Ellicott City, MD Signature of Funeral Service Light 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Danielle 23a. Part 1. Enter the disease, or complications the caused the wath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Subarachnoid hemorhise disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 2 Days -a1 Securitially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events APPROVED Due to (or as a consequence of): Exami The law requires that the death certificate be execu Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Month Year signed by the a d be detached f g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pertension. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Yes 2 No 1 Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Donatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 🕅 No APrilo6 Zo11 Fell Down Steps Investigation 6 Could not be UMEnsunM 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 2600 McCanzie Road, Ellicot City Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 17739 1spril ow ell to 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Floyd Greene Street, Balburge, MD 21201 Howell 225mth MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Naomi R. Latimer $20^{10}11$ April 9 12:56pm ^M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗶 F Days (Month, Day, Year) 4-26-1940 **Director** 219-36-0355 70 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Baltimore Reisterstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 43 Hanover Road 21136 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo should be filed within 72 hours aren usum. h and Mental Hygiene.
?? is marked other than "natural", or iten 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: Completed 3 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ll years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David L. Austin Margaret E. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 st ment of Health a tant: If item 27 is Robert W. Latimer, Sr. (husband 43 Hanover Rd. Reisterstown. MD 21136 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If if any injury or c 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 4-11-2011 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ELINE FUNERAL HOME 21a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate 3 woo (Final disease or condition resulting in death) J. Wayne Osterling 11824 Reisterstown Rd. Resiterstown MD 21136 Interval Between Onset and Death Physician/ Medical Due to (or consequence of) Examiner Sequentially list conditions, if any, leading to immediate oduce. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No. မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of within 24 hours after death.

To the Funeral Director: After t completed filled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p 18 M.D. Vento 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 7. Physician/ 2011 Victor W. Leonard 4:08 A. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Gilchrist Hospice Center Baltimore Towson Social Security Number Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 - F Min. Feb. 19, Year 942 Hours Mary land 69 **Director** 213-40-0122 Usual Residence of Decedent show 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1312 W. Jarrettsville Road 21050 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates Completed by Saltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Construction Contractor Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other them. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charlie Leonard Alta Reedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth I. Leonard / Wife 1312 W. Jarrettsville Road Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Bel Air Mem. Gardens Bel Air, Maryland 21. Signature of Funeral Senfice Ligenses Evans Tunerafachapel & Cremation Service-BelAir 3 Newport Drive Forest Hill, Maryland 21050 ons that be used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one of Interval Between Onset and Death Immediate Cause (Final Physician/ ALYNGEA CANCU disease or condition nonms resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 Yes 2 L 9 Unknown been signed by the should be detached 9 Ulnknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has performed? Yes 2 No 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ျာ 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) Manner of Death 28a. Date of injury 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural
2 Accident (Month, Day, Year) 5 Pending n 24 hours after deam.

ne Funeral Director: Aft Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier t 😓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certifier 29c. License number 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANWE 670 31. Date filed (A State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LAFFERMAN Physician/ BENJAMIN 07:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE BALT IMORE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Days Hours (Month, Day, Year) 06/30/1922 Months Min. Country) **Director** MD <u>213-18-3281</u> 88 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits MD 1 🗌 Yes 2 🙀 No BALTIMORE WHITE HALL ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20640 GREEN ROAD 21161 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1) Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) MAIL HANDLER POST OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL LAFFERMAN CELIA SHAPIRO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANIEL LAFFERMAN/SON 20640 GREEN ROAD, WHITE HALL MD 21161 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MARYLAND_VETERANS_CEM: 04/12/2011 OWINGS MILLS. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC B900 REISTERSTOWN ROAD. PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ THEROSCLEROTIC CARDIOVASCULAR disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by DEMENTIA 1 Yes 2 No 3 Probably 4. Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? certificate 2 🗌 No 2 1 N 1 Yes Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 잍 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 - Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 04-08-2011 MYSICIAN 0064533 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE GERINTALC 2434 W. BELVEDERE NE BALTIMORE MD 21215 MI 4JAN1 ABATHNDE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Box 68760

P.O.

Records,

Division of Vital

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		1- For State Registrar 1. Decedent's Nam		-	railu /	•	ficate of L		III IVICII			g. No.		3. Time of Death
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1		4a. Facility Name (2589 W. Ba	(if not institutio	n, give street and				. City, Town, o Baltimore	or Location		,	4c. C	ounty of Death	h
Funeral Director		5. Social Security I		6. Sex		(In yrs. last		If Under 1 Ye Months Da		s Min.			Foreig	
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or items 2	Funeral	11. Marital Status 1 Never Marri		arried Armed	Forces?	ver in U.S.	If Yes	Decedent of H , specify Cuba	an, Mexican	, Puerto Rica			White, etc.	ican Indian, Black,
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Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and h Important: If item 27 is n injury or other traumatic		1 X Burial 2		_	from State	e cre	matory or othe Carme	place)	•	04/14	1/11		ltimor	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Med	IF FEMALE: 23b. Was decedent past 12 months	5?	1 Live	birth	of pregnar	2 Fetal	death 3 r (Specify)	Ectopic	c pregnancy			Date of deliver onth [y Day Year
ires that the signed by the detache		Part II. Other signi	ificant conditi Lne Use	•	to death t	out not resu	lting in the und	lerlying cause	given in Pa	art I.	23e. Did to			the cause of death?
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Vital Reco hysician: The law this certificate has I director, page 2 s	Be Co	25. Was case refer	red to medical					26.Plac		(Check only				
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Division of To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical Ce	[Circuit Ciriy		nysician: To the b	est of my l									
To with	¥6	29b. Signature and		and manner	stated.			29c. Licer	se number			29d. Dat	te signed (Mo	nth, Day, Year)
		10-m	<u>)</u> L			4L /11		0.0	.M.E.			April 7	7, 2011	
)'		Name and addrDonna M. V					-	enn Stree	t, Baltime	ore, MD 2	1201			

State 31. Date filed (Month, Day, Year)
Registrar APR 13 2011

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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MELVIN APRIL 2011 12:00P M MINDEL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ENVOY OF PIKESVILLE BALTIMORE PIKESVILLE . Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Birthpiac Country) MD Days 1 🛛 M 2 🗆 F Hours Min. 08/12/1924 Director 215-22-7855 86 Yrs. Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Bant: If item 27 is marked other than "natural", or items 23a or 28a-f show lant: If item 27 is marked other than "natural", or items 23a or 28a-f show lant; Item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🎇 No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1500 BEDFORD AVENUE, #103 21208 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Midowed 4 □ Divorced Specify: Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12 PROPRIETOR LAMINATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MAX MINDEL GOLDIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other t KARL MINDEL / SON 8816 JOSHUA COURT, BALTIMORE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HEBREW YOUNG MENS 04/12/2011 WOODLAWN, MD re of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 3DIVOUTVE disease or condition Medical resulting in death) Due to (or as a conse ence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a co attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy eral Director: After this certificate filled in by the funeral director, pag 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes Other: ဂ 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) D37573 30. Name and address of person who omple d cause of death (Item 23a) (Type, Print) 7835 40515 Smyl ZAN 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 3 2011 Registrar

11-02751	
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Brandon Keyon Mackey

Please 1	Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	1	
	State of Maryland / Department of Health and Mental Hygiene	1	and the

		1- For State Registrar	Cert	ificate of De	ath		. No.	
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle, Las	KEYON F	JACKEY	/	2. Date of Death	Day Year	3. Time of Death 1106 hrs
<u>.</u>		4a. Facility Name (if not institution, give 4401 Milford Mill Road	e street and number)		y, Town, or Location of Dea esville	th	4c. County of Death Baltimore Cou	nty
Funeral Director	4	7	ex 7. Age (In yrs. las (M 2 F 23		Inder 1 Year If Under 24H onths Days Hours Mi	-	(MM/DD/YYYY) 9. Birtl Foreign 2 20 / 987 29	
ryland a-f show any f once.	ō	Usual Residence of Decedent 10a. State 10b. County ARY And	10c. City, T	own or Location Himore				10d. Inside City Limits 1 X Yes 2 No
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5-0036 stead within 72 hours a tygiene, other than "natura the Medical Examin	Completed to	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	nly highest grade completed) 1 College (1-4 or 5+)	during most of	ual Occupation (Give kind of working life. DO NOT use re able	tired)	6b. Kind of Business/Ir	dustry
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and 2 should fealth and Mc tem 27 is mattraumatic			nce-(Hother).	2216 S.	oss (Street and Number or	GAHIMORE	E MARY JANO	1 21230
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Box 68760 ne death certificate by the attending physicate for use as the bu		IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 Live birth 4 Pregnant at time of death	2 Fetal dea		ancy	23d. Date of delivery Month Da	ay Year
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ion of trending Pheath.	o Li	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	Apr 10, 2011 1	8b. Time of Injury 1058 hrs	28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe how Subject jumpe	vinjury occurred ed in front of a trai	n
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		one) 2 Medical Examiner	an: To the best of my knowledge, con the basis of examination and/and manner stated.	/or investigation, in	my opinion, death occurred	at the time, date and	d place, and due to the	cause(s)
	2	29b. Signature and title of certifier	W		O.C.M.E.	L.	9d. Date signed <i>(Mont</i> April 11, 2011	h, Day, Year)
21		-	edical Examiner 111 P	enn Street, Ba	ltimore, MD 21201			
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0	Examin		4a. Facility Name (if not institution, give Gilchrist Cen				4b. City, Tow						Baltin	ath	
	Funeral Director		5. Social Security Number 6. S 213-14-2656	7. Ag	e (In yrs. last birth	rs.	If Under 1 Y Months Da	ear	If Under Hours		8. Date of Bir (Month, Da Sept. 1	rth ay, Year) 7 1 0	Co	ountry)	tate or Foreign
	how at	۲	Usual Residence of Decedent 10a, State 10b. County		10c. City, Town	or Loc	ation				DEDC	,,,,	72 0 1 D 31		de City Limits
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980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 I If Yes, Give Year or Dates.			Vas Decedent Yes, specify C ☐ Yes 2 X				cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh	te, etc.	in,
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	vithi To th		29b. Signature and title of certifier	11.00	CONF)	29c. Lice	ense n	iumber 535	56		29d. Da	te signed (Monti	h, Day, Year	7
	10x1		6. Name and address of person who c	ompleted cause of de	eath (Item 23a) (Ty	rpe, Pr	To =	ia	4~		Russ	1 1	0 2500	Min	21205
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State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Josephine <u>Theresa</u> April <u>Micciche</u> 2011 20A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore cial Security Number 7. Age (In yrs. last birthday) 76 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Day, 216-34-3402 Days Months Director Nov1 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Md. Baltimore Rosedale 1 Tes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be r by Funeral 1315 Chesaco A<u>venue Apt.</u> S. 21237 Α, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 27 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: White 3 🗆 Widowed 4 😾 Divorced Completed Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Data Entry Esskay Meats 12thBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Pau1 Veronica Clopicki Atzinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Micciche / 1207 Apparition Lane Middle River, Md.21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 April 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Hrt of Jesus 12,2011Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facilitaczorowski Funeral Home, P.A Dundalk Avenue Baltimore, Md.21222 1201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician/ BSTRUCTIVE PULMONAR disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): nding physician and use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day cate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 E 9 ☐ Unknown JOSEPHINE 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 24 hours after death.

Funeral Director: After this certificate 1 Tes 2 No Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident work? 5 Pending 2 No filled in by the Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number 29d. Date signed (Month. Day, Year) 101 30. Name and add person who completed cause of death (Item 23a) (Type, Print 300 31. Date filed (Month, Day, Year). State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

James Oxendine	1.	- For State	Sta	te of Maryla		epartment o Ce <i>rtificate o</i>		nd Menta	al Hyg				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^D2011 Virginia Marie O'Neill April 9, 8:00 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Gilchrist Hospice Towson Baltimore 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign June 17, 1940 1 □ M 2 🛛 F Days Hours 70 220-36-5982 New York, New York **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location Director 10d. Inside City Limits be notified 28a-f Maryland Baltimore Timonium 1 Yes 2XXNo 10e. Street and Number ō 10f. Zip Code 10g Citizen of What Country? United States Funeral "natural", or items 23a Page 1 and 2 should be filed within 72 hours after death with 2317 Wuthering Road 21093 America 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: white Completed 3 X Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than "event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse 12 Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever မ Joseph John Horak Marie Estelle Holloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is Gerry Horak/ brother 123 North Mack Street Fort Collins, Colorado other t Department of Heall Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel Bel Air 1 Burial 2 Cremation 3 Removal from State 11, 4 ☐ Donation 5 ☐ Other (Specify) 2011 Forest Hill, Maryland P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Fundral Service Livens 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) icute renov Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death signed by the a 1 ☐ Yes 2> 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ syclonephatis, Chronic eron failure Records, Completed 1 🗌 Yes No 3 Probably 4 Unknown plnous Dreumonia, clostralum difficile coithis 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law has page 2 prior to completion of cause of death? autonsy performed? Yes 2 XN this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) COW'

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mc

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8 22 Physician/ PRY Month' ZARIE 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** lour owwo ounte enar Howar (1) 6. Sex 8. Date of Birth (Month, Day, 1) ocial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 262-60-4346 Months Days Hours 69 1 □ M 2 □**X**F FL Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Howard Columbia 1X Yes 2 □ No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 5838 Barnwood Place Funeral 21044 USA items ; within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ♣ No Black, White, etc. permit, Page 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or i any injury or other traumatic event, the Marie 1 once. þ 1 Never Married 2 Married ☐ Yes 1 Yes 2X No Specify: Black If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Baltimore Police Data Entry Operator Be 17. Father's Name (First, Middle, Last)
William Kegler 18. Mother's Name (First, Middle, Maiden Surname) 2 Zellinstine Davis 19a. Informant's Name/Relationship (Type, Print)
Christopher Perry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 5838 Barnwood PLace, Columbia MD 21044 20c. Location - City or Town, State FL 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 Burial 2 Cremation 3XXRemoval from State Bosque Bello Cem 4/9/11 Fernandino Beach 4 Donation 5 Other (Specify) Signal report Funeral Service Licensee Victor 22. Name and Address of Facility harles L. Stevens 501 East Fort Ave Funeral Home, Inc. Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 10104 Ph_sician/ Myocer disease or condition Medical resulting in death) nsequence of) Examiner eto 8 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury to (or as a consequence of) ABL attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? certificate has page 2 performe 1 Yes 2 No Yes 2 V No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: 2 1 No Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director; After th completed filled in by the funeral 27. Mann of Death Certificate: 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Pactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 2011 20 on who completed cause of death (Item 23a) (Type, Print) 044 CEDAR LANE 0/01/5/9 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donald W. Pelle Month 7:15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Director 212-26-9281 82 1929 Baltimore. March Usual Residence of Decedent 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Nottingham 1 🗆 Yes 2 🗖 No ò 10e. Street and Number 10g. Citizen of What Country? 'natural", or items 23a Funeral 19 Juliet Lane Unit 103 21236 United States 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: United States Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business Industry (Specify only highest grade completed) Miller Motors Buick Elementary/Seconday (0-12) College (1-4 or 5+) Parts Manager 10 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Tragesar Joseph Pelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Kathy Pelle/ Wife Juliet Lane Unit 103, Nottingham, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o Evans Funeral 1 Burial 2 X Cremation 3 Removal from State Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Bel Air 22. Name and Address of Facility
Evans Funeral Chapel &
Evans Funeral Rd Parkvi 21. Signature of Funeral Service Licensee Cremation 11e. MD 2 Approximate Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Interval Between Onset and Death Im yediate Cause (Final Phusician/ direase or condition esulting in death) **∮** Medical Due to (or as a con aquence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical Hospital or Attending Physician, The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1

Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes Other: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 5 Pending Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Tarded Sase 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PKWY, Union Memorial Hospital, SARABCHI FARDAD 201 € University 31. Date filed (Month, Day, Year). egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 710 A M **Physician** Jenn15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** MD **Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 0.9 - 0.6 - 1.955 9. Birthplace (State or Foreign Countr 1 D 7. Age (In yrs. last birthday) 55 yrs **Funeral** Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 □ No MD Baltimore, City Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code MD 2326 E. oliver St. 21213 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White, etc. 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Black ģ 3 Widowed 4 NDivorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Auto Deale_r Truck Driver/Auto Mech. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie McDuffie Alphonzia Pigatt ၉ 19a. Informant's Name/Relationship (Type. Print) Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3421 Mayfield Rd Baltimore MD 21213 Gerald Pigatt 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crem 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/19/2011 Hanover MD 22. Name and Address of Facility Phillip A Weatherford FS PA 2431 E Oliver St Baltimore Md 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Du to (or as a consequence of) attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day Month in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) completely filled in by the funeral director, Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5 Residence ၉ 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation (Month, Day Year) 1 Natural 2 Accident Injury 2 🗌 No 1 Tyes after death 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital NC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Res - 600 person who completed cause of death (Item 23a) (Type, Print) lodd 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 3:43 PM APRIL Herman Powell Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/AAGNES BALTIMORE HOSP ITA Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days · Carolina 1 🕱 M 2 🗆 F Months Hours Min. 087257 1940 238-56-5226 **Director** 70 N. Usual Residence of Decedent 28a-f shov 10b. County with the Maryland 10a. State 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 No MD N/A Baltimore 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5941 Baltimore St 21207 U.S.A permit. Page 1 and 2 should be filled within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than item? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 🗵 No Specify. 3 Widowed 4 Divorced Specify: Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Manager NIH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Powell Lillie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Powell (wife) 5941 Baltimore St., Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 04/15/11 Owings Mills, MD ያስ**ቴሮን**ክ^ለናቸ። ° ሜዋሪwn Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore,MD 21217 21. Signature of Funeral Service Licenses 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of leart failure. List only one cause on each line.

Immediate Clase (Final disease or condition Onset and Death Physician/ a. CARDIAC ARREST Medical resulting in death) Due to (or as a consequence of) Examiner 5 MINS RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transi MYCKARDIAL INFARCTION that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical JOWGLL Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) sate has been signed by the a page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be (funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined within 24 hours after

To the Funeral Dire

completed filled in b City or Town, State) Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 070718 APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 DARK SOUTH BALTIMORS MD CATON AVENUE 31. Date filed (Month, Day, Year, 32. Registrar's Signature State **APR 13** Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienefor State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8^{Day} Physician/ 20[°]f°′1 5:45 PMLeRoy Wayne Roloff April Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 53 Northwood Drive Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 □ F Months Days Hours Min. Augusta, Georgia July 27, 1952 213-70-2667 58 Director Usual Residence of Decedent 28a-f shov 10a. State 10b County 10d. Inside City Limits death with the Maryland 10c. City, Town or Location notified at Director Timonium 1 🗆 Yes 2 🔀 No Maryland Baltimore 10f. Zip Code 10e Street and Number ö On Citizen of What Country? United States of America must be Funeral items 23a 21093 53 Northwood Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian the Medical Examiner Armed Force Black, White, etc. ò \$ 1XXNever Married 2 Married Yes 2 No 3altimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural", Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Countryside Florist 12 Florist injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Department of Health and Menta Important: If item 27 is marked any injury or care. ည Lillian M. Jones Leroy O. Roloff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 53 Northwood Drive Timonium, Maryland 21093 Donald Yates/ partner 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 11, cemetery, crematory or other place)
Evans Funeral
Chapel – Bel Air 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Forest Hill, Maryland 2011 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Fune Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) anding physician and use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Year Month Day Pregnant at time of death 2 No should be detached g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has perform Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2**X** No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 12 Natural iniury 5 Pending 1 Yes 2 No Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month; Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

Sheen

8615000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 9914 4-22-11 yt. State of Maryland? Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year APRIL Physician/ STERLING RHOTEN 215 P.M 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore City 8. Date of Birth 1926 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F (Month, Day, Yea 10/07/201 Mary land 218-12-2291 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
iftem 27 is marked other than "natural", or items 23a or 28a-f show iften traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21206 United States 5924 Eurith Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1944-1X Yes 2 No 1946 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Machinist / Tool & Die 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carroll Rhoten Helen Wilson ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. Mike Rhoten (Son) P.O. Box #144, Jarrettsville, MD 21084 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 2011 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Forest Hill, Maryland Evans Funeral Chapel | April 14 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility cvans Funeral Chapel & Cremation Services-Bel Air B Newport Drive, Forest Hill, Maryland 21050 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ 6 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-transit ause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Year Day Pregnant at time of death 4 Pregnant 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 2 No 1 Inpatient 2 IER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 2 Accident
3 Suicide
4 Homicide within 24 hours after deal To the Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 5 00 18230 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samaritan Horpital, MD 21234 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ReznichenKo Year Physician/ Month NIKOLAY 301 APCIT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3809 CLARKS LANE, APT. BALTIMORE N/A Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Countr CKRAINE 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ₹ M 2 □ F Months Days Hours Min. 05408 14923 220-39-9142 85 Yrs Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director N/A MD BALTIMORE 1X Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r with 1 Funeral 3809 CLARKS LANE, APT. 304 21215 U.S.A. permit, Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Il Hygiene. I other than "natural", or iter vent, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. WHITE þ 1 ☐ Never Married 2 🛣 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MANAGER WAREHOUSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P BORIS REZNICHENKO KREYNA OSTROVSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LIDIYA REZNICHENKO / WIFE 3809 CLARKS LANE, APT.304 BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State HAR SINAI CEMETERY 04/10/2011 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): atheroscurotic cardiovascular **Examiner** distant Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicis eted filled in by the funeral director, page 2 should be detached for use as the but P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpa 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Sulcide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Pwithin 2. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSRijapalneM.D. 00057465 4 8/11 Bulh more, MDZ1209. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Jmim N -5 RujapakHIMID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 3 2011 Registrar

Elementary/Secondary (0-12) College (1-4or 5+) TAILOR TAILOR CLOTHING				Please 7	Гуре or Prin	t in Bla	ack In	delible Ink	k. Ensure A	All Copies	Are L	.egible.	
Document Superior Name (Print, (Mode), Lase) SOCIETY Name (Print) Day Year (Print) Day				_ For	State of Ma	aryland				Mental Hy	giene		11809
Physician Julius Social Security Faunce				1 - State Registrar			Cei	rtificate of	Death		Reg. No.		
TRAINING TRAINI	Г	Physici	an	Decedent's Name (First, Middle, Last)					Balonth	Day		
FUNCTION PROJECTION PR	Lot i					IAN						- '	`
		Examin	er			51200	VP	4b. City, Town,	1	1. Fr	4c. C	· .	tn
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The first Name (Prist, Middle), Assert Name (12	withir ene. than the Me	ш		College (1-4or 5	+)			euj		(ידטדאדא	IC
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Committee Comm	Ξ.	± 73 ₹ d		MARION GRUBER/DA	AUGHTER				OR COURT				
Secretary Physician Phys	ore	0 - E		· ·	Removal from State	20b. Plac	ce of Dispo netery, crei	sition (Name of matory or other pi	lace)	Date	20c. Loc	ation - City or	r Town, State
Secretary Physician Phys	≣	. E. E		4 ☐ Donation 5 ☐ Other (Specify))	WEL							
Physician Phys	ga	Depar Mpor mpor any In			see								
Physician / Medical Examiner Page Physician Phy			_		lications that caused	the death.						SVILLE	Approximate
The dical Examiner The part of the past 12 months?	Dhysisian	1 112	shock, or heart failure. List only o Immediate Cause (Final	ne cause on each lir	le.	1440	O Free!	1,120		,		interval Between	
Sequentially last conditions of the last cond	-			disease or condition	a. Due to (or as	a consequer	nce of):	1 1001					8 days
Compared to the complete of the compared of th		Examiner			bila.	kea	2 /	ly droi	replies.	85			8 days
Total Colors Tota	5	70 ±	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequer	nce of):	1.11.	Care	008			20110085
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Second Procession Seco										1□ Yes	2 □ N o	1 ☐ Ye	s 2 No
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State St	<u> </u>	nding ith. r: Afte e fun	ation	immediantian	(Month, Day	y Year)	Injury						
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29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANUVERMA MBBS 2491 West Believed. 31. Date filed (Month, Day, Year) 32. Redistrary (Martine) 33. Redistrary (Martine) 34. Redistrary (Martine) 35. Redistrary (Martine) 36. Redistrary (Martine) 37. Redistrary (Martine) 38. Redistrary (Martine) 39. Redistrary (Martine) 39. Redistrary (Martine) 39. Redistrary (Martine) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AND VERMA MBBS 2491 West Believed. 31. Date filed (Month, Pay, Year) 32. Redistrary (Martine)	5	ital or irs afte ral Di	Cer										
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HULVERMO, MBBS RE5000 Abril 06, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANU VERMA MBBS 2401 West Belvidere Avenue Balkmore MD 2121. State Begistrar APR 13 2. Resistrary (Marking)		ithin 2	Med	29b. Signature and title of certifier	and manner sta	ated.		29c. Lice	nse number		29d. Date	e signed (Mor	nth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANU VERMA MBBS 2491 West Belvedere Avenue Rathmore MD 2121. State Begistrar 31. Date filed (Month, Pay Year) 32. Resistrar 32. Resistrar 33. Resistrar 34. Resistrar 34. Resistrar 35. Resistrar 36. Resistrar 36. Resistrar 37. Resistrar 38. Resistrar 38. Resistrar 39. Resistrar 31. Date filed (Month, Pay Year)		⊢≯Fŏ		Hnu-Ver	mo, 1	186	35	RF	500	0	Abe	ilo	6,2011
State Registrar APR 13 2000 A		_ /		30. Name and address of person who c	ompleted cause of d	eath (Item 2	3a) (Type,	Print)	2 4	1	, ,	n ,	/ ' '
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			For State Registrar		State of N	iai yiai i		tificate of		Wichtairry	Reg. No.	UII	11010
	Dharini	/	Decedent's Name	e (First, Middle, L	Last)			-		2. Date of De	eath	Voor	3. Time of Death
J.	Physici: Medi		Willard			auble	<u> </u>			April	11 Day	2011	4:40 PM
	Exami	ner			ive street and number)			4b. City, Town, o	or Location of Deat	h		ounty of Death ltimor	
- 1	Funeral		5. Social Security Nu		. Sex 7. A		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs		rth	g, Birt	hplace (State or Foreign intry)
	Director		212-24-9 Usual Residence of		1 X M 2 □ F	82	Yrs.	IVIOITIIS Days	Tiours iviiii.	12/3	ay, Year) 1/1928	Ma	ryland
نے	and show dat	ğ	10a. State	10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
5	Mary 28a-f otifie	irec	MD		Arundel	G1	en Bui						1 🗆 Yes 2 🛣 No
HOp.m	ith the 23a or st be n	Funeral Director	10e. Street and Num			-		10f. Zip Code				n of What Co	untry?
工	eath w	-un-	11. Marital Status	dhill Dr	ive, Apt.	Ever in U.S	S. 13.	2106] Was Decedent of H	Hispanic Origin? (S	pecify Yes or No	U.S.	A . Race - Amer	rican Indian,
36	ifter de ", or if amine		1 Never Marri		d Armed Forces 1 1 Yes 2 If Yes, Give		1 -	f Yes, specify Cub 1 □ Yes 2 🛣 No	an, Mexican, Puerl	to Rican, etc.)	Sn	Black, White	
ö	ours a atural	Completed by	3 🛭 Widowed 4	4 Divorced 15. Decedent's	Year or Dates.			dent's Usual Occu				of Business I	nite
215	n 72 h e. ian "n Medi	dmo	(Spec	cify only highest	grade completed) College (1-4 or	5+)	(Give		during most of wo	rking	TOD. KING	oi business i	naustry
27	d withing spient	Be Co	5			,	Ma	aintenanc			•		1 Copper
2 (and	be file antal H ked of c ever	10 B	17. Father's Name (F Ernest	-irst, Middle, Las	Sauble				18. Mother's Na Eleanor	me (First, Middle		_{name)} Strauss	,
() 20 () Maryland 21215-0036	hould and Me s mar		19a. Informant's Na	me/Relationship			19b. Maili	ng Address (Street	and Number or Ru	_			
	nd 2 s ealth a m 27 i		David M.		e / Son		-		Drive, A	pt. A,	Glen B	urnie,	MD 21061
ارکار more	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.			Cremation 3	Removal from Stat	e c	emetery, crei	sition (Name of natory or other pla	:	Date		tion - City or	
Õ.	nit. Parame lartme lortani injury		4 🔼 Donation 21. Signature of	5 Other (Speneral Service Lice		Ana	-	fts Regist	ess of Facility Ar				ryland
Œ m̈	permir Depar Impor any ir	28	K	X			7	522 Conne	elley Dr.	, Ste.	P, Han		MD 21076
			23a. Part 1. Enter the shock, or hear	he disease, or co t failure. List onl	omplications that cause y one cause on each li	ed the deatl	n. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Physician/ Medical		Immediate Cause (F disease or condition resulting in death)		a. Due to (or as	m C	our c	er					Onset and Death
24	Examiner		Conventially list one	n ditions	bac to (or at	a consequ	adride ory.						
	ъ . I	Examiner	Sequentially list cor if any, leading to im cause. Enter Under	mediate	Due to (or as	a consequ	ience of):						
	oe executed ician and burial-transit	Exar	that initiated events resulting in death) L	3	c. Due to (or as	s a consequ	uence of):						
0	ath certificate be executed attending physician and for use as the burial-transi	l <u>a</u>			d								
€). Box 68760	rtificate ing phy e as th	/Med	IF FEMALE:		00 1/	. 10						1	
ox 6	ath atte for	cian,	23b. Was decedent in the past 12 n	nonths?	23c. If yes, outcom 1 Live Birth 4 Pregnant	2 Feta	l death 3	Ectopic pregnar Other (specify)	псу		230	d. Date of del Month	ivery Day Year
B.	the de by the ached	hysi	1 Yes 2 9 Unknown	□ No	9 🗌 Unknown			_ (-,,) _					
-09.	raquires that the dealeren signed by the saludid be detached	Completed by Physician/Medi	Part II. Other signifi	icant conditions	s contributing to death	but not res	ulting in the u	ınderlying cause g	iven in Part I.			f .	the cause of death?
Oct	raquire seen s should	eted								24a. Was	Δ		obably 4 Unknown
Societa	S 8 S	ompl								auto perf	opsy formed?•	prior to death?	completion of cause of
<u>= </u>	ian: The	Be C	25. Was case referre examiner?	ed to medical				26. F	Place of Death (Che	11 Yes eck only one)	2 X No	1 LJ Yes	2 No
ار م f Vital	Attending Physician: r death. ector: After this certific by the funeral director,	은	1 Yes 2	No			ER/Outpatie	nt 3 🗆 DOA		Home 5 Res			to Haspice
3.5	ding th. After funer	cate	27. Manner of Death 1 Natural 2 Accident	5 Pending Investiga	28a. Date of in (Month, D	ay, Year)	28b. Time of injury	wor	ry at 'k?] Yes 2 □ No	28d. Describe	how injury of	ccurred	*
//isio	r Atter ter dea rector	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ot be 28e. Place of in	jury - At ho tc. (Specify		eet, factory, office	_		(Street and N	umber or Rur	ral Route Number,
35	pital o												
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificat hat completed filled in by the funeral director, page.	Medical	(Check 2	Medical Exa	hysician: To the best on the basis of Iurse Practioner: To the	examination	and/or inves	tigation, in my opin	ion, death occurred	at the time, date	and place, an	d due to the c	ause(s) and manner stated.
	Vithi To the		29b. Signature and t	title of certifler	- 01.11	2		29c. Licens	se number		29d. Date s	igned (Month	, Day, Year)
			4	48/1	escant		00-1-7	IKL	4979	2	41	12/11	
			30. Name and apdre	ess of person wh	no completed cause of	death (Item	23a) (Type, נרע ג	Dulan	P. V.11	In Rd	T.m	En 112	an MD
	Sta		31. Date filed (Month		32. Regist	rar's Signal	ture		CALL CALL				21093
	Registr	ar	ADD '	1 3 2011	(A control	A.	A PORTO						

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AMEND TIEM#18perFH, G914, 4/18/2011, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month LOUIS WILLIAM SCHOCHET APRIL 2011 4:35 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TOWSON BALTIMORE GREATER BALTIMORE MEDICAL CENT If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 6. Sex 1 🛣 M 2 □ F 214-20-7442 Months Days Min. 12/29/1922 Yrs. Director Usual Residence of Decedent 28a-f shov 10a State 10b. County death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** 1 🗌 Yes 2 🔀 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 7202 ROCKLAND HILLS DRIVE, UNIT 305 21209 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) 12 BUYER FOOD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ **UNKNOWN** Miller JOSEPH SCHOCHET ANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN SANDERS/DAUGHTER 2712 APPLESEED ROAD, FINKSBURG, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State WORKMEN CIRCLE CEM 04/10/2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septic Ph sician/ disease or condition resulting in death) Medical Due o (or as a consequence of) Examiner New monia Sequentially list conditions, it is a local good in a cause. Enter Underlying Cause (Disease or linjury Examiner Date to for as a consequence of physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: signed by the attending the detached for use 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Yes 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 2 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: ည 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🖆 🇲 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0066860 n.D. 04-07-2011 andress of person who completed cause of death (Item 23a) (Type, Print) N. Chanles St Towson MD 21204 6701 ES OUNG anasen/ca 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2011 Registrar

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	State of Mai	vland / I	Department of	of Health	and Mer	ital Hygiene

		1- For State Registrar		Cer	rtificate of	Death				Reg. No.		/
Physici Medical Exami	an/	1. Decedent's Name (First, Midd	rirst, Middle,Last) athan Robert Storke							ath Day Ye		3. Time of Death 0632 hrs
Vicultal Exami	Her	4a. Facility Name (if not institution				b. City, Town	, or Location	of Death	April 8, 2	4c. County	of Death	33521110
. 10		9101 Simms Avenue				Parkville					re Cour	<u> </u>
Funeral Director		5. Social Security Number 220–39–7218	6. Sex	7, Age (In yrs. I	ast birthday) 17 Yrs.	If Under 1	Year If Und Days Hour		8. Date of B Nove 19	inber 5, 93		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a nr 28a-f show any natic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	10e. Street and Number 9101 Simms A	12. Was De Armed F 1 Yes vorced If Yes, Give Ye or Dates: cify only highest gra	cedent Ever in U. Forces? 2 No	1 16a. Decedent	10f. Zip Coo s Decedent of es, specify Cu Yes 2 X	2123 Hispanic Oriban, Mexica No specify	34 rigin? (Speen, Puerto R	ican, etc.)		what Count State I Sta	ite
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	2	19a. Informant's Name/Relations Mr. Robert A.	ship (Type, Print) Storke, J	r./fathe	19b. Mailing	•				umber, City or To e, Mary]		_'
or Heal		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other S	pecify:		Place of Disposi Crematory or oth Temorial	al Tey Garde	ns	20	Date 13 ,)11	20c. Location Timoni	-	rown, State Maryland
Baltimc permit. Page Department Important:	ļ	21. Signature of Funeral Service	£1//		Per		Alternat Ork Ros	ives F ad Tim				enter,P.A.
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Division of Vital Records, P.O. Box 68 Ta the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed					00.5	(5)	(2)	auto peri 1 ✓ Yes	opsy ormed?		empletion of cause of
Vital Rec oysician: The this certificate	B	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Mary Mark warm	Inpatient 2	ER/Outpatient		Other	·		Residence 6	✔ Other:	Scene
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Tn the Hospi within 24 hou To the Funct	Medical Co	29a. Certifier (Check only 1 Certifying P	hysician: To the be	st of my knowled	ge, death occurr			lace, and d	ue to the ca	use(s) and manne	er as state	d.
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3		30 Name and address of person Laron Locke MD. A	who completed cau		123a) 111 Penn	Street Ba	ıltimore. N	MD 2120	1	1		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ 01:08 M STEIN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner altimore timore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** (Month Bay Year) 11/09/1924 1 □ M 2 🗓 F MD Director 86 218-18-9218 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🗓 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? I Hygiene. other than "natural", or items 23a Funeral 21209 USA 6700 SAGINAW CIRCLE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Yes 2 X No Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturally injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROSE KRAMER SHURKIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6700 SAGINAW CIRCLE, BALTIMORE, MD LARRY STEIN/SON Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TIFERETH ISRAEL CEM 04/10/2011 BALTIMORE, MD 21, Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Maut 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Meck **Examiner** T Causertially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 8 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) IGHERA, DHAVAL 2011 and address of person who completed cause of death (Item 23a) (Type. Print) 1more Sinal TER ta 32. Registrar's Signature State Registrar

as

			Please T	ype or Print in State of Marylar				_		gible.	11814
			State Registrar		C	Certificate of	Death		Reg. No.		
	Physicia Media		1. Decedent's Name (First, Middle, Last) Mary S. V	erginakis				2. Date of De Month April	Dav	9ear 011	3. Time of Death 10:00 P M
	Examir		4a. Facility Name (if not institution, give str Hooper Hospice	· ·			or Location of Death t Hill	1	4c. Count Har	y of Death ford	
I	Funeral Director		5. Social Security Number 6. Sex	M 2 X F 7. Age (In yrs. 91	last birthd Yn	Months Dave		8. Date of Bird (Month, Da	y, Year)	9. Birthpla Country	ce (State or Foreign
	nd show at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town o	r Location		Toute 1	. 1010		d. Inside City Limits
8	e Maryla r 28a-f s notified	Funeral Director	MD Harfor 10e. Street and Number	d :	Bel A				40.000	N/I - 1 0	1 ☐ Yes 2 🏹 No
43	h with th rs 23a o nust be	neral	300 Sunflower C	ourt Apt.		10f. Zip Code 2101				ed Stat	
10:43pm	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 🌠 Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	.S.	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2X N		pecify Yes or No- p Rican, etc.)		ce - American ck, White, etc : Whit	· ·
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3^{1}	d be filed fental Hy rrked oth tic event	To Be	17. Father's Name (First, Middle, Last) Louis A. Sikal:	is			18. Mother's Nar	ne (First, Middle, dika Sa		ne)	
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Balti	permit. Departr Imports any inje		21. Signature of Funeral Service Licensee	Promis	Par	22. Name and Address Fu			Crema	tion	Services
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/ital	sician: The certificate l irector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	1 == /= .	Ott	Mace of Death (Chec		~	11.	15000 Na.60
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Division	≥ .≅ .⊑ _	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify				28f. Location (S City or Tow	Street and Numb n, State)	er or Rural Ro	oute Number,
Ц	To the Hospital of within 24 hours at To the Funeral D completed filled in	Medical	(Check 2 Medical Examine)	an: To the best of my know On the basis of examination	n and/or in	vestigation, in my opin	ion, death occurred a	at the time, date a	nd place, and du	e to the cause	e(s) and manner stated.
	To the within To the compl	Σ	only one) 3 \(\subseteq\) Certifying Nurse I	Practioner: To the best of m	iy knowled	29c. Licens			29d. Date signe		
	5		30. Name and address of person who com	pleted cause of death (Iten	-	pe, Print)	19776		4/10	12011	117,01.20
	Sta	te	TACKIE TONES 31. Date filed (Month, Day, Year)	CRNP 230 32. Registrar's Signa		MIANEY	VALLEY	1(1)	11/40/	IUM	MD 493
	Registra	ar	APR 1 2 201		A	held		<u>.</u>			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year Kosemary illiams 1245 PM Dai Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Memoria NIA 8. Date of Birth (Month, Day, 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F MD **Director** Usual Residence of Decedent 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No timore 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 21213 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ "natural", or Baltimore, Maryland 21215-0036 1 🗆 Yes 2 📉 vo Black Specify: Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)____ and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 9 permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the Once. rocessor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25th Baltimore MD 20a. Method of Disposition
1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 21. Signature of Fu Service Li AVE BAL 23a. Part 1. Enture the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ventricular Inbrillation disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MONOR 4 COVS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Ischemic attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Yeer's Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the aid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown plnods Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 24 hours after death.

Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🖳 No ပ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at injury 5 🗆 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 4/9/11 AT 2438946 A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore universit 301 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAKH 29 3:00A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OIN SPCTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex Funeral 1 □ M 2**X** F Days Hours Min. (Month Day, Year) 04/12/1927 Maryland Director 218-22-7882 83 Usual Residence of Deceden or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 K No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 U.S.A. 5022 Baltimore National Pike 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛮 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: 3 Widowed 4 Divorced **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Liaison Worker Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Charles Brown Mertina Monroe Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5022 Baltimore National Pike, Baltimore, MD 21229 Rosa Smith / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 04/12/2011 | Hanover, Maryland Anatamy Gifts Registry 21. Signature of Fune Servic License 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death pancreatic cancer Immediate Cause (Final le tastatic Physician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any treading to immediate cause. Enter Underlying Examine Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. -transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last as the burial the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: as been signed by the attendin 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mont Month Day Year Pregnant at time of death Unknown q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 20 After this certificate has autopsy perform the funeral director, page 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Ceath (Check only one) Hospital 2 1 Other: 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work' 5 Pending 1 ☐ Yes 2 ☐ No Accident 🗌 Investigation after death Director; / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by ☐ Homicide determined City or Town, State) 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature 3065 SICION 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 275 BaltoMD21228 700 Gerpeld 31. Date filed (Month, Day, Year, State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Harold, Williams 2011 1:30AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Monyland Medical Center Baltimore NΑ 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Days Hours 213-32-3835 1 2-30 - 35 Country) 75 MD Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified NA 1x Yes 2 ☐ No MD Baltimore 10e, Street and Number ò Apt.#714 10f. Zip Code 10g, Citizen of What Country? must be Funeral 23a USA 21217 701 N. Arlington Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etcAfrican Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ö \$ 1 Never Married 2 Married illed within 72 hours after 1 ☐ Yes 2 No Specify: Specify: American "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Jolly Construction id Mental Hygiene. marked other than 12th Grade College (1-4 or 5+) NA traumatic event, the Construction Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Baskerville James Allen Williams, Sr. Louanna and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 4207 McDowell Lane Lansdowne, MD 21227 Jessie Abbott-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 04-15-11 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licens Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Stroke Onset and Death Ph_sician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 2 **N**0 certificate Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes ၉ 1 🗹 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 187181833C 4/7/2011 M.D. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) Taffe Greene eeor Boltimore, 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\mathtt{Ap^{Month}_{r}l}$ 10^{Pay}2011^{Year} Louise Margaret Wick 5:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Days Hours Min. (Month, Day, Ye, Sept. 29 Months Baltimore, MD 87 219-14-2414 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore MD 1 🗆 Yes 2 🔀 No ö 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 8613 Quentin Avenue Funeral 21234 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married WiCK, LOUISE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Housewife At Home Elementary/Seconday (0-12) College (1-4 or 5+) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK 2 Edward Kasper Leanora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8613 Quentin Avenue, Baltimore, MD 21234 Lisa Moretti/Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State crownsville April 14, 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State Crownsville, MD Donation 5 Other (Specify) 2011 <u>Cemeterv</u> Name and Address of Facility vans Funeral 21. Sig ature of Funeral Service Licenses 22. Name and **Evans** Evans Funeral Chapel & 8800 Harford Rd. Parkvi Cremation Services . P. rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death e liate Cause (Final Pnysician/ Coronary Acute disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral injector, page 2 should be detached for use as the bunfal transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 2 -Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 유 1 Impatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0060721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 North Charles Street, Baltimore MD 21204 W Koluardo ral G.M con 31. Date filed (Mog Registrar's Signat State

Registrar

- State of Maryland Department of Health and Mental Hygiene Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 03 Day 2 9 Physician/ Blanche Walton 2011 9:00p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 1300 E. Lanvale St. Apt223 Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1 □ M 2 🎛 F Months Hours 1*2726*74907 Vírginia 103 Yrs. **Director** 213-26-2046 Usual Residence of Decedent show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director r 28a-f sh notified a 1 XYes 2 No Baltimore N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral U.S.A. 21213 1300 E. Lanvale St. Apt223 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status "natural", or iter idical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Completed er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Homes 7th Grade Domestic event, th Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Samuel Grant Hattie unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2622 Cecil Ave., Baltimore, MD 21218 Lucy L. Crowder(daughter) Department of Health Important: If item 2: any injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. 04/05/11 Baltimore, MD Zion Cem. 21. Signature of Funeral Service Licenses उठेड क्रिक्टिं कि कि own Jr. Funeral Home PA cetuch 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

CORONARY ARTERY DISEASE. Approximate CORONARY ARTERY DISEASE nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner FAILURE TO THRIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): HYPERHIPMEDIA attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last **To the Hospital or Attending Physician**: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) certificate has been signed by the irector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည this funeral 27. Manner of Death 1 D Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending Investigation Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number

State Registrar rsula

31. Date filed (Month, Day, Year)

MCCI

2323

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

mont

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 03 2011 ATTER BUR. ERALD 1105 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 9. Birthplace (State or Foreign ial Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 🗆 F 219-12-3541 Months Days Hours 85 1926 New York Yrs Feb. Director Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Funeral Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2 🛣 No 10f. Zip Code 10g. Citizen of What Country? 2059 Maidstone Farm Road 21409 U.S.A. items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates. WW II 1 ☐ Yes 2XXNo Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked of any injury or other traumatic even any injury or other traumatic even Howard Estep Atterbury Faith Ripley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Sue Atterbury/wife 2059 Maidstone Farm Road Annapolis, Maryland 21409 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 3/29/2011 Brentwood, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resciratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to me # al funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation completed filled in by the within 24 hours after deat To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certif 29c. License number Name and address of per who completed cause of death (Item 23a) (Type, Print) ANN APOUS ICH AER 31. Date filed (Month, Day, Year) 32. Regis State MAR 2920 Registrar

11-02291 Bruce Anthony Albe	Please Type or Print in Black Indelil state of Maryland / Departme		
Stuce Althory Albe	1- For State Certifica	te of Death	Reg. No.
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death 3. Time of Death
Modical Examiner	Diuce Anthony Albergo		March 24, 2011 0637 hrs
	Facility Name (if not institution, give street and number) 204 Hollins Ferry Road S.	4b. City, Town, or Location of Dea Glen Burnie	tth 4c. County of Death Anne Arundel
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth		
Director	215-80-3808 1XM 2 F 50	Yrs. Months Days Hours M	in. 1/27/1961 Foreign Country) RI
	Usual Residence of Decedent		
w any	10a. State 10b. County 10c. City, Town of	Location	10d. Inside City Limits 1 Yes 2 X No
-f sho	MD Anne Arundel Glen B	ırnie 10f. Zip Code	10g. Citizen of What Country?
the Maryland a or 28a-f sh tified at once Director			
s 23a e notif	204 Hollins Ferry Rd. S. 11. Marital Status 12. Was Decedent Ever in U.S.	21061 13. Was Decedent of Hispanic Origin? (USA Specify Yes or No- 14. Race - American Indian, Black,
r death with or items 23 must be no Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.) White, etc.
ral", or	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	1 Yes 2 X No specify:	Specify: White
hours Frantur Fed b		ecedent's Usual Occupation (Give kind o uring most of working life. DO NOT use re	
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed		ble Installer	Construction
21215-0036 vald be filed within 7 Mental Hygiene. marked other than it event, the Medical FO Be Comple	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname)
121 be fill ental H urked vent,	Michael V. Albergo	Eileen	
D 21 should and Me 7 is man		- `	r Rural Route Number, City or Town, State, Zip Code) ., Annapolis, MD 21401
mand 2 sho tealth and tem 27 is traumati	20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
TOFE ages 1 at of H tt: If i	Tr 1	y or other place) Crematory	B/28/2011 Edgewater, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	4 Donation 5 Other Specify: Kalas 21. Signal of Funeral Service Licensee		eorge P. Kalas Funeral Home
iji ji ga 🎘	Call for		land Rd., Edgewater, MD 21037
Physician Wedical	23a. Part Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	enter the mode of dying, such as cardiac	Between Onset and
≟xaminer	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ohol Abuse	Death
	Sequentially list conditions, b		
ner	if any, leading to immediate Cousse Fritar Underlyin, Cousse		
Kaminer	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
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be exe	UNPENDED AMENDED		
b. Box 68760, the death certificate be executy the attending physician and ched for use as the bunal - tra	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic preg	23d. Date of delivery nancy Month Day Year
X 68 th certi trendin r use a	past 12 months? 4 Pregnant at time of death 5	Other (Specify)	
Bo ne dear the at hed for hys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting	in the control of the	23e. Did tobacco use contribute to the cause of death?
P.O.	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part i.	1 Yes 2 No 3 Probably 4 Unknown
Records, The law requires fricate has been sig			24a. Was an 24b. Were autopsy findings available
COT:			autopsy pnor to completion of cause of death?
I Re ifficate or, pag	25. Was case referred to medical	26 Place of Death (Chec	1 Ves 2 No 1 Ves 2 No
Vital ysician ysician his certi directol	examiner?		sing Home 5 Residence 6 Other: Scene
of of ng Ph	27. Manner of Death 28a. Date of Injury 28b. T	me of Injury 28c. Injury at Work?	28d. Describe how injury occurred
ilon ttendi feath. tor: / the fi	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	
Division of Vital Records, P.O. Box 68760, sopial or Attending Physician: The law requires that the death certificate be hours after death. Journal Director: After this certificate has been signed by the attending physic y filled in by the funeral director, page 2 should be detached for use as the bur Certification: To Be Completed by Physician/Mec	3 Suicide 6 Could not be determined (Specific)	m, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
C Fill Spin	29a. Certifier 4 Contifue Physicians. To the best of my knowledge dea	h occurred at the time, date and place a	nd due to the cause(s) and manner as stated
To the Ho within 24 To the Pu complete)	one) 2 Medical Examiner:On the basis of examination and/or in		
A S S S S S S S S S S S S S S S S S S S	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

Divis

To the Hospital or A
within 24 hours after
To the Funeral Dire
completely filled in b

Pamela E. Southall, MD

31. Date filed (Month AR, 22'9 2011

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State Registrar

March 25, 2011

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 201°f 0835 Ам **Physician** G. Jeanette Ayars /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kent Chester River Hospital Center Chestertown 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 03/09/1938 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 73 Delaware 221-24-8280 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Eversive court be nettined at another. 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 □ No New Castle Newark Director DE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 19711 951 Barksdale Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mental Health Psychiatric Social Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Dawson Daniel Reese မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 951 Barksdale Rd., Newark, DE 19711 Robert O. Thomas, Sr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Mayerdale Crematory 03/24/2011 Newark, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Spicer-Mullikin Inc. 21. Signature of Funeral Service Lioshs e 1000 N. DuPont Pkwy. New Castle, DE 19720 23a. Part 1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Respiratory Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): 48hrs. Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☒ No Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown ٥. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Pulmonary Hypertention been signated b 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? 1 □ Yes 2 🖺 No 1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural he Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) To the P within 24 To the F and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceptifier 29c. License number 03/21/2011 D0069457 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kalakurthy, Samantha 100 Brown Street, Chestertown, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) parke State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien [] 1 State Amend #5, per FH, QACHD, MS, 3/29/2011
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26, 2011 MARCH 1:45 A M MILTON DANIEL ANTHONY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S QUEENSTOWN AKER ROAD Social Security Number 220-26-1034 **220-26-1037** 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Funeral 1 **X** M 2 □ F Months Days Hours , Day, Year) 23, 1931 MARYLAND Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director QUEENSTOWN 1 X Yes 2 No OUEEN ANNE'S MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21658 121 AKER ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces? Black, White, etc. ≥ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 1950–1954 Specify: WHITE Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) AMERICAN LEGION -0-BAR MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CATHERINE DADDS CHARLES NORMAN ANTHONY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

121 AKER ROAD, QUEENSTOWN, MD 21658 19a. Informant's Name/Relationship (Type, Print) PATRICIA ANTHONY/ WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARCH 30, CHESTERFIELD CEMETERY CENTREVILLE, MD 21. Signaline Furneral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). Examir -tran and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Year Pregnant at time of death 5 Other (specify) Month Day signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Q Division of Vital Records, Completed 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate l 1 ☐ Yes 2 ☐ No Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) B Hospital 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 133936 n who completed cause of death (Item 23a) (Type, Print) Dru Chesta, M32/419 Name and address of p 2108 12 Dunt 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2011 1824 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 Georgiana Elizabeth Ansart 2011 8:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 102 Timber Ridge Dr., Apt. 120 Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) 89 yrs. 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours Country) 02/09/1922 080-12-8061 **Director** NY Usual Residence of Decedent 28a-f shor 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits 1 X Yes 2 No Carroll MD Westminster ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 102 Timber Ridge Drive, Apt. 120 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Never Married 2 Married ō Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 ☐ Divorced If Yes Give "natural", Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) College Registrar Florida Inst. of Tech. other Be 17. Father's Name (First, Middle, Last) th and Mental H 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ၉ Thomas McCarthy Georgiana Brecht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Haff, daughter 692 Garden Court, Westminster, MD21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1💢 Burial 2 🗌 Cremation 3 🕷 Removal from State Florida Nat. Cemetery 04/01/2011 Bushnell, FL 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Pritts Funeral Home & Chapel MallDets 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Mercus curre Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, reauring to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Gullhludden CA Say IB 1 ☐ Yes 2 ■ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 📈 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending injury Matural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the pasie of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Praction To the I within 2 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie WJL 10 30. Name and address of person who (Item 2 a) (Type, Print) use of deal mpleted 31. Date filed (Month, Day, Year) State Registrar

Box 68760

P.O.

Records,

Vital

Division of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 29. Joyce Ann Alley 11:45 P ^M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8217 Richardson Road Clinton Prince George's Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Month, Day, You April 2, 1 1 ☐ M 2**Y**☐ F Months Hours Min. Washington DC 212 38 3743 70 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8217 Richardson Road United States 20735 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2X Married If Yes, Give Year or Dates 1 ☐ Yes 2 √ No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7
Department of Health and Mental Hygiene.
Important. If item 27 is marked other than any mjury or other traumatic manning. Elementary/Seconday (0-12) College (1-4 or 5+) Property Management Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Moore Myrtle Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Alley, Sr. (Husband) 8217 Richardson Road, Clinton, MD 20735 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XX Cremation 3 Removal from State Lee Crematory March 30, 2011 Clinton, MD 4 Donation 5 Other (Specify) Signature of Funeral Ser 22. Name and Address of Facility Eee Funeral Home, Inc 6633 Old Alexandria 509 Ferry Road, Clinton, MD 20735 23a. Part 1. Exter the dis shock, or heart failu Immediate Cause (Final sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ailure. List only one cause on each line. Interval Between Onset and Death Physician/ anoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown nemia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: \"
within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier, D0052999 fallunai MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAHIMIAN, 10403 HUSPITED DIEVE G-OG CLINTON MD 20735

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

P.O.

Records,

of Vital

Division

32. Registrar's Signature

			Pleas	se Type or Pr					-		gible.	11026
			For State	State of M	larylan		rtment of F Fificate of L		Mental Hy	.0		11020
			Registrar 1. Decedent's Name (First, Middle, I	Last)		Cert	incate of L	Jean	2. Date of D	Reg. No.		3. Time of Death
	Physicia Medi		Roy The	omus Ba	ker				Month	Day 16	Year 2011	549 PM
	Examin	ner	4a. Facility Name (if not institution, g	1 1			4b. City, Town, or	Location of Deal	th		nty of Death	
	Funeral		5. Social Security Number 6	Sex 7. As	ge (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs		irth		place (State or Foreign
	Director		Usual Residence of Decedent	1 M 2 L F	88	Yrs.	Months Days	Hours Min	. (Month, D	32 19aa	a Cour	rginia
	rland f show d at	ţ	10a. State 10b. County		10c. Cit	y, Town or Loca	ation					10d. Inside City Limits
	e Mary r 28a-i notifie	Direc	MD. Prince	Georges	N	ew (arrolto	'n				1 Yes 2 No
	filed within 72 hours after death with the Maryland al Hygiene. Jother than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at	Funeral Director	7845 Riverda	lo Dd +	H 10	2	10f. Zip Code	5		10g. Citizen o	f What Cou	ntry?
	death items ner mu	Fu	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	6. 13. W	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (S	ipecify Yes or No		ace - Americ	
336	s after al", or Exami	d by	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces? 1 1 Yes 2 1 If Yes, Give Year or Dates.		1	☐ Yes 2 No	-	to mount, otoly	Speci	lack, White,	etc.
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ylar	uld be Menta narked natic e	ြင		aker				Laura	(maid	en nam	eun	Known
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Department if item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		19a. Informant's Name/Relationship	la l		19b. Mailing	Address (Street a			. 1 1		0 .
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	Physician/	e y	Immediate Cause (Final disease or condition	y one cause on each line	Scar	1.1	inface	tion				Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (o as	a consequ		1	1	0.7			
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Z	executed an and rial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Chron	Conseque	atrice of:	al fil	prilla	tion			
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9789 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours affer death certificate be 24 hours affer death. After this certificate has been signed by the attending physicited filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE:	u								
80×6	ath cer attendi for use	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal	death 3 🔲	Ectopic pregnancy	у			Date of deliver	ery Day Year
. B.	the dea	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	t time or u	eath 5 🗆	other (specify)				101111	
//6//11 ds, P.O.	v requires that the de been signed by the should be detached		Part II. Other significant conditions			ılting in the und	derlying cause give	en in Part I.		_		ne cause of death?
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≻ lal F	cian; T ertifica ector, p		25. Was case referred to medical examiner?				26. Pla	ice of Death (Che		2 L NO	1 Yes	2 40
Rey of Vital	Physician; r this certific ral director,	2	1 Yes 2 No	Hospital: 1 Inpatie 28a. Date of injur		R/Outpatient 28b. Time of	3 DOA Othe	4 U Nursing F	lome 5 Resi)
ono	ending eath. rr: Afte	ficat	1 Natural 5 Pending 2 Accident Investigati	(Month, Day		injury	work?	y ^{at} Yes 2. ☐ No	280. Describe	how injury occu	rea	
ivisio	or Atta	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At hor . (Specify)	ne, farm, stree	, factory, office		28f. Location (ber or Rural	Route Number,
べっ	Hospital 24 hours a Funeral I	Medical	29a. Certifier 1 Certifying Pt	nysician: To the best of	my knowie	edge, death oc	cured at the time,	date and place, a	and due to the ca	use(s) and man	ner as state	ed.
SA	To the Hospital or Attending I within 24 hours after death. Yo the Funeral Director: After completed filled in by the funer		only one) 3 Certifying Nu	miner: On the basis of ex use Practioner: To the	camination	and/or investig	ation, in my opinior ath occurred at the	n, death occurred time, date and pla	at the time date:	and place, and d	ue to the car	uea(e) and manner stated
	To with corr		29b. Signature and title of certifier	1//		ino	29c. License		, [29d. Date sign	1	
	8	-	30. Name and address of person who	completed cause of de		. ,	1) POO:	3,12%		2/23	3/20	711
سيفر	47		Ronald Wheel 31. Date filed (Month, Day, Year)	er. M.D.	12	121		ile La	ne Upp	er Mary	hero	MD 20774
	Stat Registra	·	FER 2 4 2011	32. Registra	r's Signatu	re well			. 11			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 201

Physici		Registrar Decedent's Name (First, Middle, Eugene Joseph	Last) Breaux		Certificate of I		2. Date of Death Month March 25	Day	3. Time of Death 9:45 A.M
/Medic Examir		4a. Facility Name (If not institution, Heartland Health		er	4b. City, Town, or Hyattsv:	r Location of Death		4c. County o	e Georges
Funeral Director		425-70-7236	5. Sex 7. Age 1 ☑ M 2 ☐ F	e (In yrs. last birtl	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Jan. 30,	(ear) 1940	9. Birthplace (State or Foreign Country) Mississippi
Hygiene. other than "natural", or items 23a or 28a-f show ent, the Mecilcal Examiner must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County VA		10c. City, Town					10d. Inside City Limits 1 XYes 2 No
3a or 28a st be noti	Funeral Director	10e. Street and Number 1500 Woodbine St	reet	,	10f. Zip Code 2230	02		g. Citizen of W Jnited	
ital Hygiene. id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funer	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ※ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 17 Yes 2 1 If Yes, Give 1 O Year or Dates:	Ever in U.S. 958–1962	13. Was Decedent of H If Yes, specify Cub: 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	- American Indian, k, White, etc. : White
ene. than "naturs he Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	F.1	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired ntracting O:	during most of worki d)	ing		siness/Industry overnment
	To Be Co	17. Father's Name (First, Middle, L Eugene Fabian Bi				18. Mother's Name Mary Agne	es Foste	r	
h ar 7 Is trau		19a. Informant's Name/Relationshi Darlene Carnell,		69	Mailing Address (Street 99 Ole Dan 1	Road, Sout	thaven,M	38672	
nent of ant: If II ury or c		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service Actions and the service Actions are serviced to the service Action of the service of the	ecify)	George Medica	Disposition (Name of crematory or other pla LOWN UNIVER: Center 22. Name and Addre	Sity March 201	$\frac{1}{1}$ $\frac{25}{1}$	Washing	city or Town, State ston, D.C. Services, P.A.
Departr Importa any inji once,		Xut 3	De la	/M00969	9013 Annap	olic Poad	Tanham	MD 207	106
		23a. Part1. Enter the disease, or disease,	complications that caused	d the death. Do n					
Medical		23a. Part1. Enter the disease, or on shock, or heart failure. List of the shock of	Due to (or as	a consequence of	not enter the mode of dyi		or respiratory arre	st,	Approximate Interval Between Onset and Death
Medical aminer	ical Examiner	Immediate Cause (Final disease or condition	a. Due to (or as	1005041	not enter the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
d bhysician and as the burial-transit	cal	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome	a consequence of a cons	not enter the mode of dying th	ng, such as cardiac	or respiratory arre	23d. Dat	Approximate Interval Between Onset and Death
gned by the attending physician and in place of etached for use as the burial-transit and records.	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	a. Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	a consequence of a cons	ont enter the mode of dying the following of the control of the co	ng, such as cardiac of A All	or respiratory arre	23d. Dat Mo	Approximate Interval Between Onset and Death Months and Death Months and Death Months are the of delivery onth Day Year Institute to the cause of death?
as been signed by the attending physician and in pp 2 should be detached for use as the burial-transit a pro-	Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	a. Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	a consequence of a cons	ont enter the mode of dying the following of the control of the co	ng, such as cardiac of A All	23e. Did tob 1 Ve	23d. Date Mo	Approximate Interval Between Onset and Death Death Onset and D
as been signed by the attending physician and in pp 2 should be detached for use as the burial-transit a pro-	Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	a. Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	a consequence of a cons	not enter the mode of dying in the underlying cause given the underlying ca	ven in Part I. 26. Place of Deal her: 4 Wursing He	23e. Did tob 1	23d. Dat Mo	Approximate Interval Between Onset and Death Approximate Interval Between Onset Interval Between Interval Betwe
as been signed by the attending physician and in pp 2 should be detached for use as the burial-transit a pro-	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as b. Due to (or as b. Due to (or as d. Due	a consequence of a cons	ont enter the mode of dying contents the mode of dying contents. 3 Ectopic pregnance of the contents of the c	ven in Part I. 26. Place of Deather: 4 Nursing Heart All Nursing	23e. Did tob 1	23d. Date Moo	Approximate Interval Between Onset and Death Onset of Death Onset of Death Onset (Specify)
ther death. Director: After this certificate has been signed by the attending physician and in physician and physician and in physician and physician and in physician and physician and physician and physician and physician and physician and ph	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as b. Due to (or as d. Due to	a consequence of a cons	anot enter the mode of dying contents the mode of dying conficient of the mode of dying conficient of the mode of dying conficient of the underlying cause given the underlying cause g	ven in Part I. 26. Place of Deather: 4 Nursing Hearth 197 48	23e. Did tob 1	23d. Dat Mo acco use cont as 2 No ny need No e ence 6 Oth winjury occur reet and Numbon, State)	Approximate Interval Between Onset and Death Onset of Death
n. After this certificate has been signed by the funeral director, page 2 should be detached	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as b. Due to (or as c. Due to (or as d. Due to	a consequence of a cons	anot enter the mode of dying another the mode of dying and another (specify) and the underlying cause given the underlying cause	ven in Part I. 26. Place of Deather: 4 Nursing Hork? 1 Yes 2 No	23e. Did tob 1 Ye 24a. Was ar autops perform 1 Yes 2 th Check onl one 28d. Describe ho 28f. Location (St. City or Town, and due to the corred at the time, d	23d. Date Moon accourse control of the control of t	Approximate Interval Between Onset and Death Onset (Specify) Tribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No The (Specify) Tred Deer or Rural Route Number, The probability of the prior of t

Registrar

State

11-02594 Mohammed Chern	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible Bangura State of Maryland / Department of Health and Mental Hygiene	11828
	1- For State Certificate of Death Reg. No.	
Physician Medical Examine	Mohammed Cherner Bangura April 5, 2011	3. Time of Death 0937 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Oeath 7941 Johnson Avenue #114 Glenarden Prince Georg	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. B. Date of Birth(MM/DD/YYYY) 9. E. For	Birthplace (State or eign Sierra Countricone
Kue	Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location	10d. Inside City Limits
<u> </u>		1 Yes 2 No
MOTE, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show r other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Furneral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co	ountry?
ith the 23s or notifie	4207 Oglethorpe St. #103 20706 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No- 14. Race - Am	erican Indian, Black,
leath w	Armed Forces? Never Married 2 Married 2 Married 1 Yes 2 No No No No No No No	
s after c	Specify: Spe	ack
2 hours "natu		•
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exar Completed	12th Certified Nursing Asst Private	Industry
21215-0036 July be filed within 7 Mental Hygiene. marked other than ic event, the Medica	l	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Montal Hygiene. Important: If iten 27 is marked other th injury or other traumatic event, the Med	Hassan Bangura Namina Jalloh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta	te, Zip Code 2 0 7 0 6
MD and 2 sho can 27 is raumati	Mohammed Kamara/Nephew 8106 M.L. King, Jr. Hwy. #612 Gler. 20a. Method of Disposition (Name of cemetery, Date 20c. Location - City	arden, MD
Baltimore, permit. Pages 1 an Department of Hec Important: If ite	1 Burial 2 Cremation 3 Removal from State crematory or other place)	
altin mit. P. partmei portan	4 Donation 5 Other Specify: I Maryland National 14/7/2011 Laurel, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral	Home, Inc.
	cc0278 3831 Georgia Ave. NW Washingt	on,DC 2001
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Subarachnoid Hemorrhage	Approximate Interval Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of):	
<u> </u>	Sequentially list conditions, if any, leading to immediate b. Ruptured Berry Aneurysm Due to (or as a consequence of):	
nsit Examine	cause. Enter Underlying Gause (Disease or injury that initiated c. Due to (or as a consequence of):	
a and acu	a	
D. Box 68760, the death certificate be exert the attending physician iched for use as the burial-Physician/Medic.	IF FEMALE: 23a,b,27 per me g914 4-15-11 vt 23d. Date of delive	207
6876 ertifica ding ph e as the	23b. Was decedent pregnant in the past 12 months? 2 Tetal death 3 Ectopic pregnancy Month	Day Year
Box 68760, to death certificate be the attending physic red for use as the burntweiclery.	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)	
P.O. Is that the med by to detache		o the cause of death?
ords, F w requires t is been sign should be o	24a. Was an 24b. Were a	autopsy findings available
Records, The law requires fricate has been sig	autopsy prior to performed? detail? 1 ✓ Yes 2 No 1 ✓ I	
Vital Recyyleian: The his certificate director, page	25. Was case referred to medical 26. Place of Death (Check only one)	<u> </u>
n of Vil	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 V Oth	er: Scene
or: Af	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funceral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial-edical Certification: To Be Completed by Physician/Medic	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 2Be. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)	tural Route Number, City
Hospita 24 hours Fuocral rely fille		ated.
To the Hos within 24 h To the Fuo completely	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.	
1-1-00		onin, ∪ay, Year)
	30. Name and address of person who completed cause of death (Item 23a)	
	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registra		

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 24, 2011 0625 Margaret Louise Broussard Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Carroll 4102 Sykesville Rd. Finksburg 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Jan 23, Year 923 1 □ M 2 🛣 F Months Hours Min Yrs. 141-16-4123 88 Towa Director Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s notified 1 ☐ Yes 2X No MD Carroll Finksburg 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 4102 Sykesville Rd. 21048 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: White 3X Widowed 4 ☐ Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene.
marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home should be filed war and Mental Hyg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 Mary Elizabeth Fatula Charles Webster Knox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Spielman/Daughter 4102 Sykesville Rd. Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
MD Veterans Cemetery 3/29/2011 Garrison, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facili Pritts Funeral Home & Chapel, PA ohn KX 412 Washington Rd. Westminster, MD 21157 23a. Pat. . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset, nd D, ath Immediate Cause (Final Physician/ and disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 915 dequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant Pregnant at time of death 5 Other (specify) 2 100 Yes 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 1 Presidence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral! 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventioning to a stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date/signed (Month, Day, Year) 123443 3-24-11 WIL 6+5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NAYAW VAYWILA 1130 Baltimore Blvd was fransfer, MD 31. Date filed (Month, Day, Year) State Barker Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 Physician/ Charles Joseph Buckheit 20°11 6:25 ₽M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Worcester Berlin 13 Coastal Dr. Social Security Number Age (In yrs. last birthday)
78 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 ⊠ M 2 □ F Days Min. **Director** 106-22-7628 NY Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Berlin 1 Yes 2X No Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21811 13 Coastal Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Yes 2 XNo Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced white Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Me iteal 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Law Enforcement Police Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charlotte Steger Joseph Buckheit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coastal Dr., Berlin, MD 21811 wife Joan R. Buckheit 13 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State State Crem. 4/1/2011 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) First Signature of Funeral 22. Name and Address of Facility Burbage Funeral Home rvice License 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Adénocarchoma Physician/ 43/4/16 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaceo use contribute to the cause of death? þ Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Residence 6 Other (Specify) 4 hours after death. uneral Director: After the dilled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier peted (Check з 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title ustinian o completed cause of death (Item 23a) (Type, Print) 30. Name and add 8A8 31. Date filed (Month, Day, Year) State Dark. Registrar

Box 68760

P.O.

of Vital

Division

11-02354		Please Type or Print in Black Indelible In			gible.	
Robert Boyce		State of Maryland / Department of Certificate of			2011 g. No.	11832
Physiciar	1/	Decedent's Name (First, Middle,Last)		Date of Deatl Month	Day Year	3. Time of Death 0240 hrs
Medical Examine		Robert Boyce Jr. 4a. Facility Name (if not institution, give street and number)	b. City, Town, or Location of Death	March 27,	2011 4c. County of Death	
		Howard County General Hospital	Columbia		Howard	
Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	_	h(MM/DD/YYYY) 9. Bir Foreig	ın
Director	L	238 11 3125 1×M 2 F 54 Yrs.		11/26/	1956 00	untry) NC
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on n			10d. Inside City Limits
	_	NC Northampton Rich Squa	ire			1 XYes 2 No
Maryla 28a-f 1 at or	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?
with the Maryland ms 33a or 38a-f show be notified at once.	اَةِ	124 Boyce Street	27869		JSA	
uth wit tems 2	Funeral	1 Never Married 2 Married Armed Forces? If Ye	s Decedent of Hispanic Origin? (Sp s, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
ter dez		1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year	Yes 2 X No specify:		Specify Blac	:k
ours af	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	's Usual Occupation (Give kind of v		16b. Kind of Business/I	
6 72 ho	활	Elementary/Secondary (0-12) College (1-4 or 5+)	est of working life. DO NOT use reti			
21215-0036 Juld be filed within 7 Mental Hygiene. Marked other than te event, the Medica	틹	12th Car Sa	alesman		Auto Sale	S
e filed al Hyger of the	D Pe	John Russell Boyce	Doris V			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiens. The Maturally, or items 23a or 28a-f sho important: If titem 73i a marked other than "naturall", or items 23a or 28a-f sho injury or other traunattic event, the Medical Examiner must be notified at once.	하	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or F	Rural Route Num	ber, City or Town, State	Zip Code 2 1 0 4 2
MD id 2 sho lith and m 27 is			Dorsch Farm			
Baltimore, semit. Pages 1 and Department of Heal Important: If item injury or other tra		1 X Burial 2 Cremation 3 Removal from State crematory or oth		Date	20c. Location - City or	,
tim t. Pag trent riant:	L		ak Chur.Cem4/(ame and Address of FacilityWi]			
Bal permi Depar Impo			S. Main St.F			
Physician	1	23a. Part I. Entect disease, or complications that caused the death. Do not enter th failure. List only one cause on each line.		_		Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Coronary artery thrombosis				Death
		or condition resulting in death) Due to (or as a consequence of): h Atherosclerotic Cardiovascular Dise	2250			
	<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	400			
	ĘΙ	cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death). Last Due to (or as a consequence of):			<u> </u>	
	EX L	d				
O, be exe sician a		UNPENDED AMENDED			T	
Box 68760, e death certificate be ex the attending physician ed for use as the burial		IF FEMALE: 23c. If yes, outcome of pregnancy 24c. If yes, outcome of pregnancy 25c. If yes, outcome of pregnancy 25d. If yes, outcome of pregnancy 25d. If yes, outcome of pregnancy	al death 3 Ectopic pregna	ancy	23d. Date of delivery Month	ay Year
ox 6 ath cer attendi	25	4 Pregnant at time of death 5 Oth	er (Specify)	· · · · · · · · · · · · · · · · · · ·		
the de	ׅׅׅ֓֓֝֟֓֝֝ ֚	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Division of Vital Records, P.O. Box ta or Attending Physician: The law requires that the death ra after death. Tal Director: After this certificate has been signed by the atterled in by the funeral director, page 2 should be detached for the death of the death of the detached for the death of the death	≥	Chronic Obstructive Pulmonary Disease		1 Yes	2 No 3 Prob	ably 4 Unknown
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al R	۱ ا	25. Was case referred to medical examiner?	26.Place of Death (Check			
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ivisior I or Attend after death Director:	<u> </u>	2 Accident Investigation 280 Place of Injury, At home form street		28f. Location (\$	treet and Number or Ru	ral Route Number, City
Div ital or ral Di	Certification	3 Suicide 6 Could not be determined (Specify)		or Town, St	ate)	
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr one) 2 Medical Examiner: On the basis of examination and/or investigation	ed at the time, date and place, and	I due to the cause	e(s) and manner as state	ed e cause(s)
To the within To the comple	ᄝᆚ	and manner stated. 29b. Signature and title of certifier	29c. License number	3,110, date o	29d Date signed (Mor	
		(2/11/14/14)	O.C.M.E.		March 27, 2011	
4.0.5	-	30. Name and address of person who completed cause of death (Item 23a)				
187			n Street, Baltimore, MD 21	201		-
Stat Registra	3.0	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
		111111	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Badini Barry 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6506 Spring Brook Lane Clinton Prince George's 8. Date of Birth (Month, Day, Ye Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **XX**M 2 □ F Months Hours Min. 67 Washington DC Director 217 42 1933 Aug 4. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 ☐ Yes 2 XNo Maryland Prince George's Clinton 0 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 6506 Spring Brook Lane 20735 United States items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XX No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Completed Specify: 3 Widowed 4 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Programer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dominic Badini Doris Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Lipiano (Executor) 3611 Old Washington Road, Waldorf, MD 20602 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 4 Donation 5 Other (Specify) April 1, 2011 | Suitland, Maryland Signature Fuveral Savice Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final wound to The Physician/ 6 censhot disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami Due to (or as a consequence of): resulting in death) Last -pnrialattending physician Physician/Medical that the death certificate be Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown Division of Vital Records, P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? this certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of 28d. Describe how injury occurred 5/2 - 7 To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 28c. Injury at 1 Natural 5 Pending (Month, Day, Year) injunctions (Month, Day, Year) 15

28e. Place of Injuny - At home, farm, building, etc. (Specify) 1531 1 Yes 2-No Accident Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) street, factory, office completed filled in by 4 Homicide determined ome 9he Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RB15 3001 Registrar

1- For State Certificat	te of Death	Reg. No.
Registrar 1. Decedent's Name (First, Middle, Last) TOCEDIA DOMESTANCE OF COMMENTAL COMME	2. Date of Month	Death 3. Time of Death
		25, 2011 0855 hrs
12641 Southern Maryland Blvd	Dunkirk	Calvert
214-48-8776 1XX 2 F 64	day) If Under 1 Year If Under 24Hrs. 8. Date of Months Days Hours Min. SEP	of Birth(MM/DD/YYYY) 9. Birthplace (State or Poreign MARYLAN) 946
10a. State 10b. County 10c. City, Town or SPOTSYLVIANIA	PARLOW	10d. Inside City Limits 1 ☐ Yes 2 ☑ Mo
	22534	10g. Citizen of What Country? UNITED STATES
3 Widowod 4 Divorced If Yes Give Year	 13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 Xio specify: 	
or Dates:	ring most of working life. DO NOT use retired)	16b. Kind of Business/Industry GRAND UNION
	18.Mother's Name (First, Midd MARY KATH	JIe, Maiden Surname) ERINE BOWLING
19a. Informant's Name/Relationship (Type, Print) RUTH E. BOWLING / WIFE 19b. 97	700 EDENTON ROAD, PAR	RLOW, VA 22534
1 X Xurial 2 Cremation 3 Removal from State BOWLI 4 Donation 5 Other Specify:	y or other place) .NG FAMILY MAR. 29 .METERY 2011	
21. Signature of Funeral Service Voens TERRENCE L. JOHNSON #M00993	22. Name and Address of Facility TERRENCE L. JOHNSON 4433 WHITE PLAINS LA	FUNERAL SERVICE, PA NE WHITE PLAINS, MD
failure. List only one cause on each line.		Between Onset and Ceath
Sequentially list conditions, b		
▼ UNPENDED □ AMENDED 23a,27,per	me,g915 6-2-11 sm	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown 9 Unknown	the underlying square given in Port I	Did tobacco use contribute to the cause of death?
And the second s		Yes 2 No 3 Probably 4 Unknown
	a	Vas an 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical	26.Place of Death (Check only one)	Yes 2 No 1 Yes 2 No
examiner?		Residence 6 Other: Scene
	me of Injury 28c. Injury at Work? 28d. Descri	ribe how injury occurred
	1 Yes 2 No	
1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	m, street, factory, office building, etc. 28f. Locati	on (Street and Number or Rural Route Number, City vn, State)
1 Natural 5 Pending (Month, Day, Yeer) 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 29a Certifier	n, street, factory, office building, etc. 28f. Location Town occurred at the time, date and place, and due to the restigation, in my opinion, death occurred at the time, date and occurred at the time, date and place.	cause(s) and manner as stated. date and place, and due to the cause(s)
1 Natural 2 Accident 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 29b. Place of Injury - At home, farm (Specify) 29c. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or inv	n, street, factory, office building, etc. 28f. Location Town	vn, State) cause(s) and manner as stated.
by highermoreal Evaluation	5. Social Security Number 214-48-8776 1	Aa. Facility Name (if not institution, give street and number) 1264 Southern Maryland Blvd Southern Marylan

Zabiullah Ali, M.D. Assista

State 31. Date filed (Month, Day, Year)

Registrar MAR 3 0 2011

ORIGINAL

OUME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MANUEL RIVAS BERTOLO 20^{Year}1 5:45 AM MARCH 27, Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XXX 2 □ F Months Hours (Month, Day, Year) 09-21-1931 223-80-2219 **Director** 79 SPAIN Usual Residence of Decedent show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director CLINTON MD PRINCE GEORGES 1 Yes 2 XXIVo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20735 by Funeral 12611 WINDBROOK DRIVE SPAIN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 XX Arried ☐ Yes 2**X**No Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 YYes 2 No Specify: SPANISH Specify: SPANISH If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
STONE & MARBLE MASON 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) CONSTRUCTION (LOCAL 2 UNION) of Health and Mental Hygiene. Elementary/Seconday (0-12) 8 TH College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnarne) 2 ESPERNAZA BERTOLO SIEIRO AURELIO RIVAS TROITINO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH C. MOTTA BERTOLO (WIFE) 12611 WINDBROOK DRIVE, CLINTON, MD 20735 Baltimore, Date 30, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot MAR. RIVERDALE^y PARK CREMATORY 1 ☐ Burial 2XX remation 3 ☐ Removal from State RIVERDALE, MD 4 Donation 5 Other (Specify) 2011 21. Signalure (Suneral Service Licen) Signalure (Eureral Service Licent PA)
TERRENCE L. JOHNSON #M00993 4433 WHITE PLAINS LANE, WHITE PLAINS, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, sician/ neumay disease or condition resulting in death) Medical Due # (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause Enter Inderlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): anding physician a Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death 1 Yes 2 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an dementic autopsy Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Matural iniurv 5 Pending death. 2 Accident
3 Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 3 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

MAR 31

32. Reg

			Please T	ype or Print in Black					11000
		1	For State	State of Maryland / Do	epartment of Hea Ce <i>rtificate of Dea</i>			1000	11000
			Registrar 1. Decedent's Name (First, Middle, Last)		pertincate or Dea	1	Reg. I 2. Date of Death		3. Time of Death
	Physicia	n/	Anwar A. Rh	a+ti			March	Day 24 Year 22	11 STAM
	Medic Examin	_	4a. Facility Name (if not institution, give st		4b. City, Town, or Loca	ation of Death		4c. County of Deat	
أيمعيها			N Ov th we the House Social Security Number 16. Sex	7. Age (In yrs. last birtho	Kary 411	Under 24 Hrs.	8. Date of Birth	0.01	hplace (State or Foreign
T	Funeral Director		067_86-32 W Usual Residence of Decedent	M 2 □ F 66 Y1	Months Days Ho	ours Min.	(Month, Day, Yea	944 Con	Intro) PAKISTAN
	land shov	tor	10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
	28a-i)irec	MD BALTIM	ORE OWIN	GS MILL		100	Citizen of What Co	1 Yes 2 □ No
	ith the	ral	10e. Street and Number	RD. APT. #3A	21117		109.	USA	undy?
	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Funeral Director	11. Marital Status	Was Decedent Ever in U.S.	13. Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Spec	cify Yes or No-	14. Race - Ame	
36	fter de	2	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2' No If Yes, Give		exican, Puerto r	ilcari, etc.,	Black, White	S/AN
Ö	ours a atural	eted	3 Widowed 4 Divorced	Year or Dates.	Decedent's Usual Occupation		16h	. Kind of Business	
75	א 25 ה an "na Medic	mp	(Specify only highest grade Elementary/Seconday (0-12)	e completed) (0	Give kind of work done during fe. DO NOT use retired)	g most of workir	ng		
213	within ygiene.	Be Completed	/2	Company C	ASHIER			ALMA	-R1
and	e filed ntal Hy ed oth event:	To B	17. Father's Name (First, Middle, Last)	CHSH BHAT"	and a	Mother's Name	(First, Middle, Maid		
Maryland 21215-0036	ould b nd Mer mark matic		MOHAMMAD BAK 19a. Informant's Name/Relationship (Typ)		Mailing Address (Street and N				code) 2008
	d 2 sh alth ar n 27 is er trau		MUHAMMAD MI						
Baltimore,	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland ortinent of Health and Mental Hygiene. ordant: If item 27 is marked other than "natural", or items 23a or 28a-f show ordant: If item 27 is marked other than "natural", or items 25a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.e.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ F	20b. Place of I cemetery,	Disposition (Name of crematory or other place)			. Location - City or	
tim	t. Page rtment c rtant: If rjury or		4 ☐ Donation 5 ☐ Other (Specify)	TSUM	22. Name and Address of				AD PAKISTAN
Bal	permit. Page 1 a Department of F Important: If ite any injury or ot		21. Signature of Funeral Service Licenses		11242 EAS		VOODBRI.		A. 22191
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cations that caused the death. Do no	t enter the mode of dying, su				Approximate Interval Between
	nysician/		Immediate Cause (Final disease or condition	ASC V D					Onset and Death
أميرا	Medical Examiner		resulting in death)	Due to (or as a consequence of	:				
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	ted J ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury					_1,1	
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687	ertifica Iding p	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy				23d. Date of de	livery
P.O. Box 68760	requires that the death certificate be ex- been signed by the attending physician should be detached for use as the burial	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
0.	t the c by the	Phys	g ☐ Unknowh Part II. Other significant conditions cor		the underlying cause given it	n Part I.	23e Did tobace	co use contribute to	o the cause of death?
Э,	res the signed	d by	Tart II. Other algillineant conditions on	and the death part nev researching in					Probably Unknown
ord	requii been should	Completed					24a. Was an	24b. Were at	utopsy findings available completion of cause of
Sec.	he law te has age 2	omb					autopsy performed 1 \(\sum \) Yes 2	death?	s 21 No
alF	ian: T artifica ctor, p	Be C	25. Was case referred to medical examiner?			of Death (Check			
Zit	hysic this ce al dire	မ	1 🗆 Yes 2 🗐 🗸	ospital: 1			me 5 Residence		cify)
n o	ding F h. After funer	ate	27. Manne of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation		ury work?	2 🗆 No	28d. Describe how it	njury occurred	
Division of Vital Records,	Atten er deal ector: by the	Certificate:	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, factory, office		28f. Location (Stree City or Town, St		ural Route Number,
Δį	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physici sted filled in by the funeral director, page 2 should be detached for use as the but the funeral director.								
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	(Check 2 Medical Evamin	cian: To the best of my knowledge, d er: On the basis of examination and/or Practioner: To the best of my knowle	investigation, in my opinion, d	leath occurred at	the time, date and p	lace, and due to the	cause(s) and manner stated.
	To the within 2 To the comple	Σ	only one) 3 Li Certifying Nurse 29b. Signature and title of certifier	Tradition to the best of my knowle	29c. License nui		29d.	Date signed (Mon	th, Day, Year)
			M JUL MD			2650		3-29-1	1
R	2		30. Name and address of person who co	1. ((1) 2) 1.		Adam (town M	Dails	>
1 `	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	it road sa	violett)	100-10 1-1	2 6113	5
	Registr		MAR 3 0 2011	Marke					

11-02531		Please Type or Print in Black Indelible			jible.	11937			
Whitney Lynn E	Benn	otato of maryland, bopartmone		ygiene	2011	11007			
		1- For State Certificate	of Death		g. No.				
Physic Medical Exam		1. Decedent's Name (First, Middle,Last) Whitney Lynn Bennett		2. Date of Death Month April 2, 20	Day Year	3. Time of Death 0915 hrs			
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
		woods across from 29031 Pond Run Rd	Westover		Somerset				
Funeral Director) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	_	h(MM/DD/YYYY) 9. Birt 3-1987 Foreign Cou				
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits			
. .	١.	Delaware Sussex Delmar				1 Yes 2 No			
Aaryland 28a-f show Lat once.	턍	10e. Street and Number	10f. Zip Code	110	g. Citizen of What Coun				
th the Maryland 23a or 28a-f sho notified at once.	Director	36739 Susan Beach Road	19940		United Stat	tes			
with t s 23s	<u></u>	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-					
leath w	Funeral	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.				
after d u", or ner m	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 No specify:		Specify: W	nite			
5-0036 led within 72 hours af tygiene. other than "natural the Medical Examin		15. Decedent's Education (Specify only highest grade completed) 16a. Dece	dent's Usual Occupation (Give kind of w g most of working life. DO NOT use retir		16b. Kind of Business/Ir	ndustry			
16 n 72 l ical)	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		,	D	T			
003 withii giene.	E	17. Father's Name (First, Middle, Last)	lomemaker	(First Addulla Ad	Domestic	Engineer			
filed filed at the	Be C	Franklin Bennett	18.Mother's Name	in Benne	1				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	To B		iling Address (Street and Number or R			Zip Code)			
sho and si 7	_	Robin Benett Mother 3673				19940			
Ore, Mes I and 2 of Health If item 2			position (Name of cemetery,	Date	20c. Location - City or	rown, State			
Baltimore, permit. Pages I an Department of Hee Important: If ite		T Dana 2 Tolliation o Trollioval Irolli otato	otherplace) Pry Crematory		Salisbu	ıry, Md.			
Baltimo permit. Page Department o Important: injury or oth			2. Name and Address of Facility	inmon Eu					
		M00295 1	.1673 Somerset Ave	· Prince	ineral Home ess Anne, Mo	1. 21853			
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	er the mode of dying, such as cardiac or	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and			
/Medical £xaminer		Immediate Cause (Final disease a. Asphyxia				Death			
		or condition resulting in death) Due to (or as a consequence of):							
	-	Sequentially list conditions, if any, leading to immediate b							
	mi	cause. Enter Underlying Cause (Disease or injury that initiated							
xecuted n and - transit	Examiner	events resulting in death) Last Due to (or as a consequence of): d.							
ਂ ਜ਼ਵ	dical	▼ UNPENDED ☐ AMENDED 23a,27,28a-f	per me g914 4-22-	11 vt					
Box 68760, e death certificate be exusthe attending physician ed for use as the burial -	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy	Fetal death 3 Ectopic pregnar		23d. Date of delivery	Van			
c 68 certil ending use as	ciar	past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnar Other (Specify)	ncy	Month D	ay Year			
Boy death the att	ysi	1 Yes 2 No 9 V Unknown 9 Unknown	Othor (openny)						
		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		pacco use contribute to the				
Division of Vital Records, P.O. tal or attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	8				2 ✓ No 3 Proof				
Cords, law requir has been s	ple			24a. Was a eutops	y prior to co	opsy findings available empletion of cause of			
Rec The la	1 Yes 2 No 3 Prooa 24a. Was an eutopsy performed? 1 ✓ Yes 2 No 1 Ves 2 No 1								
Vital Reysician: The his certificate director, page	Be (25. Was case referred to medical examiner?	26.Place of Death (Check of						
FVI Physic or this ral dir	ဥ	1 ✓ Yes 2 No Prospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time 6			Residence 6 🗹 Other:	Scene			
n of viding Ph. h. After t	Ö	1 Natural 5 Rending (Month, Dey, Year)	1 Ves 2 X No		• •	ل معمد ف			
isior Attend rector: by the	icat	2 Accident Investigation II 4-Z-II II 9:	15am		was asphyx				
DIVI pital or ours afte neral Dir	Certification:	Suicide Sui		or Town, Sta	ate) across fi	rom 29031 ver, Md.			
Hospi 24 hou Funer ely fil		29a Certifier	curred at the time, date and place, and						
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Medical	one) 2 Medical Examiner: Of the basis of examination and/or investi							
	ž	29b. Signature and title of certifier	29c, License number		29d. Date signed (Mon	h, Day, Year)			
			O.C.M.E.		April 3, 2011				
OCME		30. Name and address of person who completed cause of death (Item 23a)	11 Donn Street Dolling	D 24204					
	0,0	24 Data filed (Marth Day Vand) 22 Pagistrada Sindatura	11 Penn Street, Baltimore, MI	U 21201					
Regis		APR 1 4 2011 Surve 8. April			_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2312 Joseph F. Colandreo March 26 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Month, Day Yea 1 X M 2 □ F Months Min 87 1923 Washington. **Director** 577-20-1670 Usual Residence of Decedent Show 10a. State 10b. County with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13201 Tamarack Road 20904 U.S.A. death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No 1942 -Black White etc. 1 Never Married 2 Married þ hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Specify. 1946 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Seconday (0-12) Coflege (1-4 or 5+) Superintendant Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antonio Colandreo Maria Pompa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 21 any injury or other to once. Mariann F. Jensen - Daughter 14602 Liberty Road. Mount Airy. Maryland 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/30/2011 Rockville, Maryland Parklawn Mem. Park 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee ala 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line Year to be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Pnysician/ Pneumonia - Community Acquired disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner COPD Exacerbation Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Atrial Fibrillation and Due to (or as a consequence of) resulting in death) Last burial-1 attending physician for use as the buria Physician/Medical The law requires that the death certificate be Congestive Heart Failure Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate ☐ Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Certificate: To 1 \(\) Inpatient 2 \(\) ER/Outpatient 3 \(\) DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 Yes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier only one apo title of certif 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) +1 MD0065069 March 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Sirak Hagos Lemma,

MAR 29 2011

31. Date filed (Month, Day, Year)

37. Registrar's Signature

M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 29 Day 2011 Physician/ Collazo 5:45 Rafae1 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Olney Montgomery General Hospital 8. Date of Birth (Month, Day,) March 3, 9. Birthplace (State or Foreign Country)
Puerto Rico If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 🖾 M 2 🗆 F Months Days Min 82 581-52-5424 Yrs Director Usual Residence of Decedent Show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Silver Spring MD Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 20906 USA 3005 S. Leisure World Blvd., 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian traumatic event, the Medical Examiner Armed Forces? Black, White, etc ō 1 Never Married 2 X Married Completed by Specify: White 1 🗓 Yes 2 □ No Specify: Puerto Rican If Yes, Give Year or Dates 'natural" 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. d other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Providencia Camuñas Casto Collazo permit. Page 1 and 2 should I Department of Heaith and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5801 Nicholson Lane, #1521, North Bethesda, MD 20852 Santiago Collazo/Son injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State March 30 2011 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA Name and Address of Facility and is and is J. Collins Funeral Home Inc. 0 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ therosclero disease or condition resulting in death) ueans Medical Due to (or as a consequence of) **Examiner** years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated exacts). Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the burial Physician/Medical yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death g ☐ Unknown Month Dav Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by <u>verebrovascu</u> 2 No 3 Probably 4 Unknown ar 5805E 1 Yes should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Pulmonar After this certificate has performed Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ဂ္ဂ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 2 Accide 5 Pending work?
1 Yes 2 No Investigation Accident 2' ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1) 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) tatucia

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

one

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:40 am Nancu 28 March 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Vietnam 6. Sex If Under Year If Under 24 Hrs. **Funeral** 8. Date of Birth 1 🗆 M 2 🗶 F (Month, Day, Year) 01/01/1944 Months Min. Hours **Director** 212-35-0119 67 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 1400 Fenwick Lane, #407 20910 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 A Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Asian Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Quy Cao Lieu Thi Vo 1 and 2 should to of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hanson C. Nguyen - Son 601 Deerhead Court, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Der mit. Page 1 a
Der artment of H
Important: If ite
any injury or ot 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park 03/31/2011 | Rockville, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pneumonia disease or condition week Medical resulting in death) Due to (or as a consequence of): Examiner Bronchogenic Lung Cancer Years Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Ditie to (or as a consequence or, ysician and e burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 phy: the IF FEMALE Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records, or Attending Physician: The law requires Sepsis Completed 1 ☐ Yes 2 🖎 No 3 ☐ Probably 4 ☐ Unknown Hypercapnic Respiratory Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Division after death. ☐ Accident Investigation 1 Yes 2 No the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) Supanich, ESM NO D 0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Supanich, RSM, MD, 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) MAR 3 0 2011 State Registrar

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DHMH 17 Rev 7/2009

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ا اسمدیده	Examin	er	4a. Facility Name (if not in 4) 7 8	2099	y 13 ras	e (In yrs. las	Rd	4b. City, Town,	or Location of Deat Lers C	75	m		th Conery thplace (State or Poreign
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	and show	tor		. County		10c. City,	Town or Loca	ation					10d. Inside City Limits
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Maryland 21215-0036	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at the Medical Examiner must be notified at	by	1 Never Married 2		Armed Forces? 1 ☐ Yes 2 [X] If Yes, Give Year or Dates.	[No	1	Yes, specify Cub ☐ Yes 2 X N	oan, Mexican, Puert o Specify:	o Rican, etc.)		Black, Whit	
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ij	Page ment o tant: If jury or		1 ☐ Burial 2 ☐ Cri 4 ☐ Donation 5 ☐	Other (Specify)	00		li Cem		04/]	14/11			est Indes
Baltimore,	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral S	Service Lice			/	Name and Addr		Snowden			
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P	nysician/		shock, or heart failu Immediate Cause (Final disease or condition	ure. List only one	cause on each line	1	4						Interval Between Onset and Death
	Medical Examiner		resulting in death)		Due to (or as	a conseque	nce of):	70m_					11116
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	e executed sian and urial-transit		resulting in death) Last		Due to (or as	a conseque	nce of):	-					
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Box 68760	ending use as	an/M	IF FEMALE: 23b. Was decedent pregr	I all	Bc. If yes, outcome			Ectopic pregnar	ICV		23	3d. Date of de	livery
. Bo	To the Hospital or Attending Physician; The law requires that the death certilicate be within 24 hours affect death. To the Luneral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	in the past 12 month 1 Yes 2 Ho 9 Unknown	ns?	4 Pregnant a 9 Unknown			Other (specify)	,			Month	Day Year
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E E	siciant. The la certificate ha rector, page	Ф	25. Was case referred to	medical				26. [Place of Death (Che		ormed? 2 No	1 ☐ Ye	s 2 No
Vita	ysicia nis cert direct	To B	examiner? 1 X Yes 2 No	H	ospital: 1	ent 2 🗆 El	R/Outpatient	- Int	her.	lome 5 🔀 Resi	dence 6	Other (Spec	cify)
Jo C	Ing Pl		27. Manner of Death 1 ☐ Natural 5 ☐	Pending	28a. Date of inju (Month, Day		8b. Time of injury	28c. Inju	rk?	28d. Describe			hamma
sior	Attend r death ctor: /	Certificate:	2 ☐ Accident 3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Investigation Could not be	may 26 a		しっす e, farm, stree		Yes 2 X No	5 < 1 5 -			Iral Route/Number
<u> </u>	o the hospital or Attending Physician: To the Funeral Director: After this certific completed filled in by the funeral director,		4 🗆 Horricide	determined	building, etc		Hon			City or To		26VAS	mo 2057 4
:	Hosp 24 hou Fune leted fi	Medical	Check 2 M	ledical Examine	er: On the basis of e	xamination a	and/or investig	ation, in my opin		at the time, date	and place, a	nd due to the	cause(s) and manner stated.
:	То th e within То the сотр	2	only one) 3 L C 29b. Signature and title of		A A	Dest of my k	mowledge, de	29c. Licens			29d. Date	signed (Monti	
	6		gu 3	ns	recher	mo	DME	10	0045	8	may	२४	2011
			30. Name and address of	•				nt) 9	1/ver 9	anks	560	2000	20-16
	Stat	te	31. Date filed (Month, Day	y, Year)	A. Registra	ar's Signatur	e L	11	IIVer 9	PVIT	7 18	10 3	0904
	Registra		MAR (3 0 2011	Ceran	J.	Mars						

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

of Vital Records,

Division

Please Type or Print in Black Indelible Ink Firsure All Copies Are Legible. Amend I tem 26 per med Cerrk Ginsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ TAMES DOMINICK COX, SR. MARCH 2011 8:45P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9995 MARSHALL CORNER ROAD CHARLES WHITE PLAINS 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Month, Day, NOV • 21 1X XM 2 | F 90 MĂRYLAND Director 219-01-5167 9201 Usual Residence of Decedent 28a-f show 10a. State must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD CHARLES WHITE PLAINS 1 Yes 2 XXV 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 9995 MARSHALL CORNER ROAD 20695 U. S. A. or items hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Date W . W . I I 1 ☐ Yes 2XXNo Specify. "natural", Specify: 3 Widowed 4 Divorced Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.

7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER AND OPERATOR HEATING OIL BUS. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ೭ JESSE ARTHUR COX ANNA CECELIA MUDD permit. Page 1 and 2 should be Department of Health and Menr Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20695ROSE ANNA COX / SPOUSE 9995 MARSHALL CORNER RD., WHITE PLAINS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State APRIT 1 ★ Burial 2 Cremation 3 Removal from State crematory or other place TRINITY MEM.GRDNS. 8,2011 4 Donation 5 Other (Specify) WALDORF, MD 21. Signature of Funeral Service License 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. ans 15 M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ THRIVE I-AILURE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter chaoriting Examine Due to (or as a consequence of) burial-transi Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No ò Pregnant at time of death Month Day Vear 5 Other (specify) 9 Unknown the detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š DERTENSION pe 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 💆 unknown Completed page 2 should peen DOOJIZAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy performed? Yes 2 140 certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Thinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending (Month, Day, Year) 1 🖫 Naturai 24 hours after death.

Funeral Director: A Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL Mellun ShVINKUMAR Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month рМ Elaine 26. Smith March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months July 17 1 🗆 M 2X 🗆 F 83 Hours Min. 220-38-3261 Director DC Usual Residence of Decedent 28a-f shov 10b. County 10a, State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No MD Laure1 Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9733 Evening Bird Lane 20723 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No Maryland 21215-0036 within 72 hours after Specify: White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☒ Divorced ted Year or Dates. the Medical Complet 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Chief of Customer Service Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of George Arthur Smith Rosalie Frances Smith other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a : If item 27 is Paul L. Downs/Son 9733 Evening Bird Lane, Laurel, MD 20723 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 permit. Page 1 Department of Important: If if any injury or o 1 ☐ Burial 🌠 Cremation 3 ☐ Removal from State March₁ 28, Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA Signature of Funera Service Francis Address Collins Funeral Home Inc. 1 p00 University Blvd. W., Silver Spring,MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 15 years Immediate Cause (Final Physician disease or condition Aortic Stenosis years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or impury that initiated events Due to (or as a consequence of): the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. I ρ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 🗌 No Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Assisted Living Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence \(\text{SC} \) Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) MU. D56531 March 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li, MD 8600 Snowden River Parkway, Columbia, MD 21045 31. Date filed (Month, Day, Year)
MAR 29 2011 State Registrar

			For	Piea	Se Type or Pi State of N							_	-		11845
		1	State Registrar				-	tificate					eg. No.		11010
400	Physicia Medi		Decedent's Name	DIANE		DANI	EL					ate of Deat onth ARCH		2011 Year	3. Time of Death 5:35 P M
	Examir	ner	•		give street and number) GE'S HOSPIT				own, or EVRE	Location of D	Death			County of Death PRINCE G	EORGE'S
	Funeral Director		5. Social Security Nu 577-64-9	646	6. Sex 7. A	ige (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours		ate of Birth Ionth, Day V • 23	Year) 194	9. Birth Court 4 PENN	place (State or Foreign stry) SYLVANIA
	ryland -f show ied at	ctor	Usual Residence of 10a. State	10b. County			ty, Town or Lo								10d. Inside City Limits 1 Yes 2 □ No
	the Ma a or 28a be notif	Funeral Director	MD 10e. Street and Num		E GEORGE'S	UPP	ER MAR	LBORO 10f. Zip (Code			1	l0g. Citiz	en of What Cou	
	th with ms 23, must	mera	1209 TO	RINGTO					774				USA		
9036	within 72 hours after death with the Maryland giene. giene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	2	11. Marital Status 1 □ Never Marrio 3灯 Widowed 4		12. Was Decedent Armed Forces 1 Yes 2X If Yes, Give Year or Dates.	t Ever in U. ? ☐ No	1:	Vas Decede f Yes, specif	fy Cubai	n, Mexican, F	n? (Specify Ye Puerto Rican,	es or No- etc.)		4. Race - Americ Black, White, pecify: BL	
Baltimore, Maryland 21215-0036	nin 72 hou ne. .han "natu e Medical	Completed	Elementary/Seco	nday (0-12)	t's Education tt grade completed) College (1-4 or	· 5+)	(Give I	lent's Usual kind of work O NOT use r	done d	ation Juring most of	f working		16b. Kin	d of Business In	dustry
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, Mar	CV II N I		19a. Informant's Nat	IEL JR			19b. Mailir 104	g Address (Street a	nd Number of LEET NE	or Rural Route EW BRI	PAIN,	City or To	own, State, Zip 0 06053	Code)
imore	permit. Page 1 and Department of Heal Important: If item 3 any injury or other		20a. Method of Disp 1 X Burial 2 D 4 Donation	Cremation	3 ☐ Removal from Stat	e (Place of Dispo cemetery, cren RMONY	natory or oth	her place	e)	Date 4/4/20	- 1		ation - City or To	
Balt	permit. Departi Import any inji		21. Signatu ol 5 n	eral S e Li	censee										HOME, INC. ND 20785
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Ì	be executed sician and burial-transit	l Examiner	cause. Enter Underl Cause (Disease or ii that initiated events resulting in death) L	injury	c. Due to (or as										
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. Box 6876	To the hospital of Attending Priystoan. The law requires that the death certificate within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	1 🥆 1	IF FEMALE: 23b. Was decedent p in the past 12 1 ☐ Yes 2 9 ☐ Unknown	ionths?	23c. If yes, outcom 1	2 Fet at time of	al death 3	Ectopic pro Other (spe		У			23	3d. Date of delive	ery Day Year
ls, P.O	signed by	ğ	Part II. Other signific	cant condition	ns contributing to death	but not res	sulting in the u	nderlying ca	ause giv	en in Part I.	23			e contribute to th	ne cause of death?
Division of Vital Records, P.O.	ne law req te has bee lage 2 shot	Completed									-	4a. Was ar autops perform	у	24b. Were auto prior to co death? 1 \sum Yes	psy findings available impletion of cause of
alF	rtifica ctor, p		25. Was case referred examiner?	d to medical	1				26. Pla	ce of Death ((Check only o		NO	1 🗀 163	220110
<u>;</u>	nysic his ce Il direc	To Be	1/D Yes 2 -				ER/Outpatien	t 3 🗆 DOA	Othe	r: 4 □ Nursi	ing Home 5	Reside	nce 6	Other (Specify)
on of	ath. r: After t	Certificate:	27. Manner of Death 1 Natural Accident	5 Pending	ation		28b. Time of injury	280 M	c. Injury work? 1 🔲 '	at ? Yes 2 🗌 No		escribe ho	w injury o	occurred	
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	within 24 hours To the Funeral completed filled	Medical		Medical Ex	Physician: To the best of aminer: On the basis of Nurse Practioner: To the	examinatio	n and/or invest	igation, in my	y opinio	n, death occu	rred at the tim	ne, date and	d place, a	and due to the ça	use(s) and manner stated.
	With Co.		29b. Signature and H	te of certifier	relan			29c. l	License	number	3/8	2	9d. Date	signed (Month,	Day Rear)
R	6		30. Name and address	ss of person w	no completed cause of	death (Item	23a) (Type, P	rint)	//	DR.	Chi	1001	(1)	mn	21385
	Stat Registra	ı.e	31. Date filed (Month)		32. Regist	rar's Signa	ture	1/1/0	, 4		- 15C V		7		- W / J J J

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 11-02246 Keon Andre Dobbs 1- For State Registrar Reg. No.

Physici Medical Exami		Keon Ar									"	Month March 22,	Day	Year	3.	1502 hrs
		4a. Facility Name (if St. Agnes Ho		n, give street and no	umber)		4	b. City, Town, Baltimore		etion of De	eath		4c. C	ounty of De	ath	
Funeral		5. Social Security Nu	•	6. Sex	7. Age (Ir	n yrs. last bir	thday)	If Under 1		f Under 24	Hrs. 8	B. Date of Birt	h(MM/DD	YYYY1 9.	Birthp	lace (State or
Director		212-39-833		1 M 2 F		17	Yrs.		_		Min.	04/03/		For	eign Count	Maryland
		Usual Residence of D		16-1M 2 F			TIS.		\perp						- COUIT	
any .			0b. County		100	c. City, Town	or Locatio	on							10	d. Inside City Limits
		MD	Balti	more			На	lethor	oe -						1	Yes 2 No
Maryland 28a-f show d at once.	돯	10e. Street and Num	ber					10f. Zip Cod				10	g. Citizen	of What C	ountry	?
with the Maryland ns 23a nr 28a-f sho be notified at once.	Director	57 Biro	knoll	Court				21.	227					USA		
with 18 23	펻	11. Marital Status		12. Was De		er in U.S.	13. Was	_		ic Origin?	(Speci	fy Yes or No-	14	Race - An	nericar	n Indian, Black,
death r iten	Funeral	1 X Never Married	1 2 Ma	rried Armed F	orces?	No	If Ye	s, specify Cu	ban, Me	exican, Pue	erto Ric	can, etc.)		White, etc		rican
after al., n	by	3 Widowed	-	orced if Yes, Give Yes	ar		1 🗌	Yes 2	No s	pecify:			Sp	ecify: Ame		
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nor ages are int of art. If		1 X Burial 2	_		rom State		ory or oth	• ,	ne (, mor	2 / 20)/2011	Crow	metri 1	۵۱	MD
Baltimore, permit. Pages I at Department of He Important: If ite injury nr nether tr	1.5	4 Donation 5 21. Signature of Fund				DELLAT		ame and Addr		- 141		ll Fune			10	, 110
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Physician		23a Part I. Enter the failure. List only			aused the	death. Do no	ot enter th	e mode of dyi	ng, suc	h as cardia	c or re	spiratory arre	st, shock,	or heart		Approximate Interval Between Onset and
/Medicul xaminer		Immediate Cause (Fi		a. Shotgun P	ellet Wo	unds										Death
Adminier		or condition resulting		Due to (or as	a consequ	ence of):										
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	ji.	if any, leading to imn cause. Enter Underl	ying Cause	C.												
ъ .	Examiner	(Disease or injury the events resulting in de		Due to (or as	a consequ	ence of):										
i, P.O. Box 68760, ries that the death certificate be executed signed by the attending physician and be detached for use as the bucal - transi	F			d											-	
O, be ex	Physician/Medical	UNPENDED		AMENDED												
G8760, certificate be nding physicise as the buck	Ě	IF FEMALE: 23b. Was decedent pi		23c. If yes,		of pregnancy		al death	3 🗆	Ectopic pre	anana	,		ate of deliver	/ery Day	Year
x 68	E.	past 12 months?		4 Pregi		6 -1		er (Specify)	<u>-</u> П	_ctopic pre	griaricy		IVIC	<i>/</i> 1101	Day	1001
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ords, P.O. Box 6 w requires that the death cer s been signed by the attendi		Part II. Other signific	cant conditi	ons contributing t	o death bu	t not resultin	g in the ur	nderlying caus	se give	n in Part I.			_			cause of death?
signe	d by										_	1Yes	2 🗸 N	0 3 F	robab	ly 4 Unknown
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he lay	Ē							-				perform	med?	death 1	1?	2 No
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Vital Records hysician: The law requithis certificate has been I director, page 2 should	To Be	examiner? 1 ✓ Yes 2	No	Hospital: 1	Inpatient	2 ER/O	utpatient	3 ✓ DOA	Oth	er4 🔲 Nu	ırsing H	lome 5 🔲 I	Residence	6 🗌 01	ther:	
Division of Vital Records, ral ar Attending Physician: The law requir is after death. al Directar: After this certificate has been seled in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.		27. Manner of Death		28a. Date	of Injury	28b.	Time of In	jury 28c. I	Injury a	t Work?		d. Describe h		оссипед		
itendi for:	읉	1 Natural 2 Accident	5 Pend	ing Mar 22,	2011 (Par)	144	5 hrs	1	Yes	2 🗸 No	30	ibject snot				
ivis after d Direc	E		6 Could	not be 28e. Plac	e of Injury	- At home, f	arm, stree	t, factory, offic	ce build	ling, etc.	28	f. Location (S or Town, St		Number or	Rural	Route Number, City
ppital oours filled	Certification:	4 Homicide	deter	mined (Specify)	Local	Street					38	81 McDowe	II Lane, I	ansdown	e, Mo	d.
Division of Vital Records, P.O. Bc within 24 hours after death. To the Hospital ar Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached for		(on to one of the		ysician: To the be												augo(a)
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3		30 Name and addres		who completed cau nt Medical Exa			n Street	t, Baltimor	e MI	21201						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ 2:17 201 A Helen Elizabeth Davis Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico Salisbury 1811 Mt. Hermon Rd. 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 4 /9 / 19 22 1 M 2 F 88 MD Director 214-36-5344 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Wicomico Salsibury MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21804 1811 Mt. Hermon Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give white Completed 3

Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Own Home 6 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amanda Pruitt Harry Daisey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1811 Mt. Hermon Rd., Salsibury, MD 21804 Bonnie Murray / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Important: I any injury o Willards Cemetery 3/28/2011 Willards, MD 4 ☐ Donation 5 ☐ Other (Specify) of Fundal Service License 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 mba 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one caus, on e caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Mille Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death certificate has been signed by the a rector, page 2 should be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate; To Be examiner? Other: 4 \(\text{Nursing Home} \) 1 Nursing Home 5 Residence 6 \(\text{Other} \) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) eral Director: After thi filled in by the funeral 28c. Injury at work? 1 \square Yes 2 \square No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 30. Name and address of person who completed cause of the UIAH CIGNNZAWZ, ath (Item 23a) (Type, Print) ANKLIN AUG. DER UN, MD 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3:05 p M Vivian Josephine Dohner March 24 Day 2011 Year Physician/ Medical 4a. Facility Name (if not institution, give street and numitable alth Care 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster Carroll Carroll Lutheran Village Center 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Days (Month, Day, 95 Months Hours New York 1915 249-60-4728 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director Westminster Carroll Maryland 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21158 Funeral 205 St. Mark Way, Apt 407 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates ☐ Yes 2 No Specify: white 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William Langewisch Catherine Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6130 Sebring Drive, Columbia, MD 21044 John Dohner, stepson item 2 b. Place of Disposition (Name of Gness crehauror other place) Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Marriottsville, MD 3/29/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ature of Funeral Service Licensee 22. Name and Address of Facility Myers—Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 山太 23a. Part)1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
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1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate has 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 은 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by 4 Homicide within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier WJL ompleted cause of death (Item 23a) (Type, Print) 51, 31. Date filed (Month, Day, Year, 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 9:40 pm Erma Frances Donaway March 27 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Somerse lanokin rincess 8. Date of Birth (Month, Day, Year) 12/6/1932 7. Age (In yrs. last birthday, (State or Foreign **Funeral** 1 □ M 2**X**□ F 214-28-1665 78 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ XNo Director Wicomico Marion Station 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 30164 Hudsons Corner Rd. 21838 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify þ Specify: white 3 XWidowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Poultry Grower Poultry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 be t Clarence Elmo Peititt Gussie Rae Dryden ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21838 Evelyn Robertson/daughter 301 Hudsons Corner Rd., Marion Station, MD permit. Pages 1 and Department of Healt Important: If Item 2: any injury or other 1 once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation Riverside Cemetery 3/4/2011 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the challenge of the caused the complex of the caused Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SYCAVS DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) pate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) I □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Plage of Death (Check only one) 1 Yes 2 No Hospital: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred **Hospital or Attending** V Natural s after dea... ai Director: Aftr 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1051359 March 2815 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 · S. DIVISION ST Dr USITA NATES AN SALISAURY MD 21804 ET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 3 0 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 0910 A James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Olney Montgomery Montgomery General Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 | F 1070271946 North Carolina Director 245-72-0313 64 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Gaithersburg Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 17116 Queen Victoria Court apt.#102 20877 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in the and Mental Hygiene.
7 Is marked other than "r Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Government 10th Forklift Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James R. DeBrew Grace Exum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17116 Queen Victoria Ct., apt.#102 Gaithersburg, MD 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trans Sally DeBrew/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Harmony Memorial Park 04/01/2011 Landover, MD 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licensee 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as consequence of) **Examiner** Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed enal sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical W Box 68760 IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death ed by the 2 🗆 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hepatiz Foilure Completed 2 XNo 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Cougulopathy page 2 s has autopsy perform certificate 1 ☐ Yes 2 ☒ No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 XNo 1 XInpatient 2 - ER/Outpatient 3 - DOA 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be □ Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number MD060335 24,2011 Bannen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year)
MAR 3 0 2011 32. Registra 's Sigr State Registrar

State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 03 915 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death aroline aroline Denton 9. Birthplace (State or Foreign Country) Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days 12-03-1920 Director 90 216-14-9585 PAUsual Residence of Decedent 28a-f show 10a State 10c. City Town or Location with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10d. Inside City Limits Director MD Caroline 1 X Yes 2 No Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 514 Lincoln Street 21629 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Custodian Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ of Health and Ments fitem 27 is marked rother traumatic e Page 1 and 2 should be Gootie Emory Margaret Christopher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Emory / Daughter 608 Lincoln Street, Denton, Maryland 21629 Department of Healt Important; If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03-30-11 Hurlock, Maryland E. Veterans 21. Signatur of Fineral Service Lionnee Bennie Smith Funeral Home 426 Dover Street, Easton, Md. 21601 23a. Part 1. Enter the disease, or complications that caused the d ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final Ph_sician/ disease or condition resulting in death) PAY Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for a in the past 12 months? Pregnant at time of death Unknown Month 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an death? After this certificate Yes 2 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 14 Natural injury 5 Pending Accident Suicide 1 Yes 2 No Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 14 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 2 4VA Na 31. Date filed (Mor MAR 28 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20ÏI MARCH 20:20 PM DAVID WORTH ENGLAND Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CECIL 616 BAILIFF ROAD NORTH EAST Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 **X** M 2 □ F Min. JULY 31 , 1934 MARYLAND **Director** 218-32-2477 76 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10b. County 10c, City, Town or Location 10d, Inside City Limits Director MARYLAND CECIL NORTH EAST 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 616 BAILIFF ROAD 21901 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2XXMarried hours after Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2X No Specify: If Yes, Give "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HEAVY EQUIPMENT OPERATOR CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ ALBERT H. ENGLAND OLIVE WORTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a LORRAINE ENGLAND / SPOUSE 21901 616 BAILIFF ROAD, NORTH EAST, MARYLAND item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth APRIPEte 2, Burial 2 Cremation 3 Removal from State 4 Donation 3 Other (Specify) cemetery, crematory or other place) FRIENDS CEMETERY 2011 CALVERT, MARYLAND 21. Signature of June 1 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the resease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear/failure. List only one cause on each line.

Immediate Cause (Final disease or con lion resulting in death)

a. Public (or see Interval Between Onset and Death Pnysician/ OBSTAU CTIVE CHRONIC Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine If any leading to in reclats cause. Enter Underlying Disk to for as a nonsequence on ig physician and as the burial-transit requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death detached 9 Unknown 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed nas been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page performed or Attending Physician; The 1 Yes 2 No 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 1 Yes 2 No death. Accident Investigation after death the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO NETHOOD MARCH 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH STREET SUITE #3 DAVID GAR-EL 304-306 ELKTON MALTLAND 21931

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State

Registrar

31. Date filed (Month, Day, Year) MAR 3 1 2011

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🖯 🗍 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 28^{Day} Month 3 Physician/ 2011 Edward Charles Edwards 7:18 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 25 Camelot Circle Worcester Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 12/1/1929 9. Birthplace (State or Foreign Country) NY Social Security Number 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) Funeral Days Min. Hours Director 81 099-22-7955 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director MD Worcester Berlin 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 25 Camelot Circle USA permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, <u>the Medical Examiner mu</u> Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black White etc. 1 Never Married 2 Married Completed by Yes, Give 1 ☐ Yes 2x No Specify: Specify:White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Oil Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Edwards Emma Heins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryanne Edwards/wife Camelot Circle Berlin MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First State Crem 3/31/2011 Milsboro DE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 108 William St Mison The Burbage Funeral Home 21811 Berlin MD 23a. Parf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ COPD , eva stace disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Athal Fibrillation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 N this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) angela Sillesuns 00066169 3/30/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10445 Old Ocean City Blud #1, Berlin MO Z1811 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

DHMH 17 Rev 7/2009

Registrar

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 25. Leonard Joseph Farello 1550 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Ye March_10 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 □ F Country) New York Hours Director 101-36-4684 66 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 9227 Manchester Road 20901 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0 Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Divorced 4 Divorced White Year or Dates. injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Teacher/Coach Education permit. Page 1 and 2 should be filed wit Depar ment of Health and Mental Hygie Imporant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angelina Palotta John Farello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toni Theresa Farello - Spouse 9227 Manchester Road, Silver Spring, Maryland 20901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 💆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) Lincoln Crematory 04/04/2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Katni Tuguson 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complicit in significant shock, or heart failure. List only one cause on each line. Immediate Cause (Final Days Physician/ E. Coli Septic Shock disease or condition Medical resulting in death) Examiner Acute Respiratory Failure Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Acute Renal Failure Days Due to (or as a consequence of Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? Day Year detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Severe Anemia 1 2 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Lung Cancer with Metastases to Liver & Spine 24a. Was an autopsy performed? Yes 2 No Severe Thrombocytopenia 1 Yes 2 No Physician: Be 25. Was case referred to medical of Vital completed filled in by the funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 1 No မ 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury Division 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral L Medical 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Barbara Supernely RSM MID D 0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Supanich, RSM, MD, 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year)

NAR 3 0 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State
Registra MFND#5 per INF, 4/8/11; BMW, McCo Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ \mathbf{P}^{M} 4:00 Geller March Medical Irving 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital Birthpra Country) g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth If Under 1 **Funeral** 822-Min 1 **X** M 2 □ F Months Days Hours 0/26/1925 Director Usual Residence of Decedent 10d, Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number Funeral 20906 3005 S. Leisure World Blvd. #8D8 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1

Yes 2 □ No Black White, etc. 1 Never Married 2 X Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify If Yes Give 3 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) National permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Institutes Of Health 5+ Scientist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Nellie Siegel Benjamin Geller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090619a. Informant's Name/Relationship (Type, Print) Leisure World Blvd. #8D8 Silver Spring MD Emily Geller / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Rurial 2 X Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/26/2011 National Falls Church, VA Crematory 22. Name and Address of Facility Danzansky-Goldberg 170 Rockville Pike Signature J Femoral S Memorial Chapels Inc. Rockville, MD 20852 **Blake** Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Days Congestive Heart Failure disease or condition Medica resulting in death) Due to (or as a consequence of) Examiner Months Coronary Artery Disease Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-rethat initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Year in the past 12 months? Month Day Pregnant at time of death 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 ☐ No 3 ☐ Probably 4 🏝 Unknown Atrial Abrillation, Renal Failure 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Diabetes, Hypothyroid, Cholesterol autopsy performed? Yes 2 X No: death? 1 Yes 2 🗌 No After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical the funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No X Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: 5 Pending work 1 X Natural 1 🗌 Yes 2 🗎 No М death. Accident Suicide Investigation 24 hours after deat Puneral Director; 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) bleted filled in by Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) thin 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number (ÎA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. Suite # 209 Silver Spring, MD 20902 10301 Georgia Anuradha Arun M.D2 9 2011 State Registrar

			_ For	State of N					Health and			_		118	59
		1 - State Registrar Certificate of De									Reg. No.			1 1 0	
	Physicia Medi		1. Decedent's Name (First, Middle, Last) Daniel Gampel								eath 22, Dá	⊉011 Yea	r .	3. Time of 1 835 A	Death M _M
	Examir	4a. Facility Name (if not institution, give street and number)					4b. City, Town, or Location of Death				4c. County of Death				
	Funeral	Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda					Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of B				Montgomery			Foreign	
	Director		577-42-3033 1 M 2 F 83 Yrs. Month						Hours Min.		ay, 1 19=12	7 j	ontripiac Portal	e (State or nd	Foreign
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	of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	irec	MD Montgomery Silver Sprin				rin	ing						1X Yes	2 🗆 No
2		Completed by Funeral Director	10e. Street and Number 11316 Newport Mill Road				10f. Zip Code 20902				10g. Citizen of What Country? United States				
9	or item		11. Marital Status 1 Never Married 2 Married 2 Widowed 4 Diversed 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give			1	B. Was Decedent of Hispanic Origin? (Specify Yes or North Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.				
Maryland 21215-0036	nours an atural", ical Exa		Year or Dates.				1 ☐ Yes 2 🛣 No Specify:				Specify: White				
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and	oe med antal H ced ot c ever	Tagge Campol					18. Mother's Name (First, Middle				e, Maiden Surname)				
Jan J	nd Me mark mark	Issac Gampel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route No.													
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Ball	Depart Depart Impor any in		21. Signature of Funeral Section 1	censee Mt	1163	De De	. Name anza	and Addres	ss of Facility Goldberg O Rockvi	Memoria 1Te Pik	al Cl	napels ckville	Inc	D 208	52
Н			23a. Part 1. Enter the disease, or a shock, of heart failure. List or	complications that cause nly one cause on each li	ed the deat								Ar	proximate erval Betw	
PI	Ph sician/ Medical Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of):								Onset and Death						
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ION C	leath. tor: After the fune	al Certificate:	1 Natural 5 Pending (Month, Day, Year) inju			injury	work? M 1 Yes 2 No			28d. Describe how injury occurred					
DIVIS ital or At	within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)						
he Hosp	in 24 hoi he Fune	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								ner stated.				
29b. Signature and title of certifier							29c. License number D70217				29d. Date signed (Month, Day, Year) March 23, 2011				
	3		30. Name and address of person w	•	•		•	MD 0	0006						
	Stat	e	31. Date filed (Month, Day, Year)	941 Ferrara 32 Aegist					0900						
	Registra		MAR 29	2011		d. ba	Mar								11

11-02213 Punyasara Gedara

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 O State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		ertificate of	Death		Re	g. No.			
Physici		Decedent's Name (First, Middle,Last)	runuusut	a Gedara			Date of Death Month	n Day Year	3. Time of Death		
dical Exami	ner	aka Tuckambate de		ra Wickr	amanayak 1b. City, Town, or 1	e	March 21,	2011	1702 hrs		
		4a. Facility Name (if not institution, give Suburban Hospital	street and number)	ľ	Bethesda	Location of Dea	itn	4c. County of Dea Montgomery	tn		
Funeral		Social Security Number 6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year	+	i.e.	h (MM/DD/YYYY) 9. B	irthplace (State or		
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any .	ctor	Usual Residence of Decedent 10a. State 10b. County	I10c. C	ity, Town or Locati	on				10d. Inside City Limits		
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Maryland 28a-f show d at ooce.		Maryland Montgom 10e. Street and Number	lery		10f. Zip Code	Olney		g. Citizen of What Co			
with the Maryland ms 23a or 28a-f sho be notified at ooce.	Director	3407 Bant	3407 Bantry Way			20832		Sri Lanka			
h with the sms 23a Lbe noti	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?		s Decedent of Hisp es, specify Cuban,	panic Origin? (Specify Yes or No-	14. Race - Ame White, etc.	rican Indian, Black,		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland b and Mental Hygiene. 27 is marked other than "oatural", or items 23a or 28a-f sho matic ereot, the Medical Examiner must be notified at occ.		1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 X No		Yes 2X No		to recom, ote.y	Specify:	Asian		
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Baltim permit. Pa Departmer Importantinjury or		21. Signature of Funeral Service License			ame and Address	of Facility Hi	nes-Rina	ldi Funera	l Home, Inc.		
		Delungun	m	118	00 New H	ampshir	e Ave., S.	ilver Spri	ng, MD 20904		
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interve									
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2B ₹	Examiner	(Disease or injury that initiated events resulting in death) Last									
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760, icate be extra physician the burial	2	IF FEMALE:	23c. If yes, outcome of pr	egnancy				23d. Date of delive	ry		
		23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of	double "		Ectopic pregi	nancy	Month	Day Year		
Box 68	Physiciar	1 Yes 2 No 9 Unknown	4 Pregnant at time of 9 Unknown	death 5 Oth	ner (Specify)						
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f Vi Physical this	2	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	✓ ER/Outpatient 28b. Time of Ir	• 🔲 - • • •	Other Nurs	sing Home 5 F	Residence 6 Other	er:		
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Division tal or Atteodi rs after death.	fica	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, etc. 28f. Location (Street and Number 28e. Place of Injury - At home, farm, street, factory, etc. 28f. Place of Injury - At home,									
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Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the control of the								29d. Date signed (Month, Day, Year)			
								March 22, 2011			
30. Name and address of person who completed cause of death (ftem 23a)											
		Theodore M. King, Jr., MD.	Assistant Medica			eet, Baltimo	re, MD 21201				
St Regis	ate		32. Registrar's Sign	ature fav	10						

State of Maryland / Department of Health and Mental Hygiene [7] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^D2011 Month March 1:22 PM Earl S. Grove Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges 2517 Senator Ave. District Heights Social Security Number 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral (Month, April Director 178-12-5272 91 Beaver. Usual Residence of Decedent or 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 X No Maryland Prince Georges District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2517 Senator Ave. 20747 United States and 2 should be filed within 72 hours after death w Health and Mental Hygiene. em 27 is marked other than "natural", or items: 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Xes 2 No 1044If Yes, Give 1046 Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ You Specify: 1946 3 X Widowed 4 Divorced Specify: Completed White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Glazier Glass Industry/Construction Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Frank Grove Nellie Elizabeth Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Grove (Son) 2517 Senator Ave, District Heights, MD 20747 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemetery 4/6/2011 Cheltenham, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria MO1555 Ferry Road, Clinton, MD 20735 23a. Patvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) hrombocylo Medical **Examiner** Pancytopenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Lusuly " that the death certificate be executed Nen use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 L 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ b Hospital or Attending Physician: The law requires to 24 hours after death.
b Hours after death.
c Funeral Director: After this certificate has been sign. Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsy performed' death? 1 Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 \square Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 124 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MISIOT Venn Lui Suik Jed Upper morthus mit de 772 EVKIUS Welbert mo 9560 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Yvette Barbara Gutrick 8:03A Medical March 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9176 Cherry Lane Prince Georges Laurel 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days 1 □ M 2X F Min. $Ma_y^{(Month_3^{Day}_1^{Year})} 54$ Hours Maryland Director 215-62-8270 56 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD PG 1 X Yes 2 No Laurel 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 9176 Cherry Lane 20708 United States permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Payroll Clerk Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ု Lewellyn Burroughs Catherine Greer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1806-B Solomon Road
Charlottesville, VA 22901 Brian Gutrick/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 3/30/11 Riverdale Park Crematory 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, Md. 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part 1 Enter the dis shock, or heart failu Immediate Cause (Final Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Ph_sician/ a Chronic Obstructive Lung Disease disease or condition Years Medical resulting in death) **Examiner** Hypertension Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Obesity Years the burial-trar Due to (or as a consequence of): resulting in death) Last signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Schizophrenic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury 1 Ves 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number D28998 Name and address of person who completed cause of death (Item 23a) (Type, Print) 9101 Cherry M.D. State MAR 3 0 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death P March 2 4ay 2011 Physician/ Barbara Geraldine Green Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Ac. County of Death Prince Georges Examiner Prince George's Hospital Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F 66 Yrs. Months Hours Min. Wash. 577-62-0097 DC Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat" any injury or other traumatic event." 10d. Inside City Limits 10b. County 10c. City, Town or Location Landover 10a State Director Frince George MD 1X Yes 2 ☐ No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Funeral 20785 1604 Electric Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Black 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hotel Industry Housekeeping Be 18. Mother's Name (First, Middle, Maiden Surname)
Ruth Johnson 17. Father's Name (First, Middle, Last) Oliver Smallwood ပ 19a. Informant's Name/Relationship (Type, Print)
Kevin Green/ Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1604 Electric Ave. Landover, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ME Oliver Cem. April 2, 2010 Wash., 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pridgen Funeral Service Juawara Lanham, MD 20706 9013 Annapolis Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final puxia Physician/ disease or condition Medical resulting in death) Due to or as a consequence of): Examiner bulmonari Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Meumon To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending humanian and as been signed by the at ending physician and 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 2 1-110 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mellitue 1 Yes 2 No 3 Probably 4 DUnknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death?

1
Yes 2
No within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s Hypertenave performed Cardiovaccular difeare 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 1 Inpatient 2 🗆 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifiers 29d. Date signed (Month. Day, Year) March 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PG Horpita MAM 13011 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 1 0258 A M Archer Gittens Michael 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Washington Hagerstown Social Security Number If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 02 12 1 XM 2 □ F Months Hours Min Barbados 137-52-2776 1947 Director 64 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits the Maryland 10c. City, Town or Location Completed by Funeral Director must be notified PA Franklin Waynesboro 28a-f 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23a 319 Valley View Dr. 17268 US ral", or items? Examiner mus Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian rmed Forces?

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Yes, Give Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes X No Specify: Black "natural", 3 Divorced 4 Divorced Year or Dates the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Hepartment store salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ Archibald S. Gittens Elsie E. Inniss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .8 Health tem 27 319 Valley View Dr. Waynesboro, PA Maymonna Gittens/spouse item 20111^{20c. Location - City or Town, State} 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April Date ō ₩. 6 1

Burial 2

Cremation 3

Removal from State Important: It any injury or Waynesboro, PA 17268 4 Donation 5 Donation 5 Donation Cumberland Valley Crematorium 21. Signature of Funeral Service Licensee Grove-Bowersox Funeral Home, Inc. 22. Name and Address of Facility 50 S. Waynesboro , PA Broad St. 23a. Part 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury -tran that initiated events resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant :
9 Unknown 3 🗌 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Year Pregnant at time of death Yes 2 No detached 1 L Yes 2 L sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 10 No မ ₹R/Outpatient 3 ☐ DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier ade 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) gistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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4 Homicide determined 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)												on (Stree Town, S		er or Rura	Route Number,				
	_	unera unera	Medical	29a. Certifier 1	Certifying	Physician: To	the best of r	ny knowle	edge, death o	ccured at 1	he time,	date and	place, and	d due to th	e cause	(s) and mann	er as state	ed.	
	4	the F		only one) 3	☐ Certifying	Nurse Practio	ner: To the b	est of my	and/or invest knowledge, d	gation, in n	ed at the	n, death or time, date	courred at and plac	the time, die, and due	ate and I	place, and du luse(s) and ma	e to the ca anner as si	use(s) and manner stated. ated.	
29b. Signature and title of certifier.											- 1	d. Date signed		•					
				- JW	necel	M	100	00	18	11	06	933	6		FY	MKCH	24	2011	
				30. Name and addre				ath (Item 2 1901		,	E AL	EAN	Dust	D		1444	MAA	I. A.A.A	
1		Stat	e	 Date filed (Month) 	n, Day, Year)		2. Registra				ENI	CR D	KIVE	- 150	OCKI	TILLE	MAR	ILHND	
		Registra		MAF	29 20		- Lucia	B.	and the same										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 03-23-2011 3:00 ам Herrera .Tose Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 9. Birthplace (State or Foreign Country) Cuba If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Min. (Month, Day, Year) 11-29-1924 1 X M 2 □ F Director 213-45-0235 86 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No Prince George Hyattsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3601 Gallatin St. #723 20782 U.S.A. "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: Specify Hisp**anic** Completed 3 Divorced Cuban Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Driver Train 12th item 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jose Magdaleno Herrera Petrona Pedroso 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Macuran Gonzales 3601 Gallatin St. #723 Hyattsville, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ە <u>=</u> 9 1 🐰 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) 04-01-11 Fort Lincoln Brentwood, Maryland Signatur of Funeral Service License 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 3447 14th St. NW. Washington, DC 20010 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of Examiner 18 chays UT SPD Secuentially list conditions Examine if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown peen 24b. Were autopsy findings available prior to completion of cause of has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

Afto the Funeral Director: After this certificate I for the Funeral Directory. After this open and the page of t Yes 1 X Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| We describe the cause of 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0062604 arch 25,2011 who completed cause of death (Item 23a) (Type, Print) Alida Andriollo-Eginoza, 7600 CARRULL AURNUR TAKOMA Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 03/ 2011 10:30 A M 24/ Bertha R. Hightower Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7851 Burnside Road Landover Prince George's . Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1 M 2 F Hours 58 **Director** 577-72-7239 07/21/1952 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Landover Prince George's MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 7851 Burnside Road 20785 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 K No Black, White, etc. þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2X No Specify: Completed 3 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Zone Supervisor Private 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Will Hightower Mary Martin permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 562 Serenity Court, Apt.#G, Odenton, MD 20785 Kisha N. Hightower/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify), 04/01/2011 Landover, Maryland Harmony Memorial 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Liq 5538 Marlboro Pike, Forestville, MD 20747 010108 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myocardial Infarction Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Cardiac Pulmonary Arrest Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death g Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 🏝 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No မှ 1 Inpatient 2 ER/Outpatient 3 DCA To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the ba (Check to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) MD 10544 DC

Sta

DHMH 17 Rev 7/2009

Registrar

1647 Benning Road, NE Washington DC 20002, Suite#200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Edwin Chapman

31. Date filed (Month, Day, Yes

MAR 3 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) Date of Death Month 2:36 Physician/ Virginia Louise Hunt Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Lanham Doctors Community Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** OFTO' 90 Feb. 1,7921 Months Days Hours 1 - M 2 - F 278-26-9155 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10b. County 10a. State with the Maryland Examiner must be notified at Director 1 Yes 2 □ No Greenbelt Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number P United States 20770 23a Funeral 58J Crescent Road or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Page 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ģ ☐ Yes 2 🔀 No White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates 27 is marked other than "natural", traumatic event, the Medical Exal 3 X Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) own home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ila Alspach ည George Giffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5613 Dover Street Churchton, Maryland 20733 19a. Informant's Name/Relationship (Type, Print) Christopher Hunt -son or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/4/2011 Van Wert, Ohio Woodland Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Bonard ViceBofgwardt Funeral Home, PA 21. Signature of Funeral Service Licenses Maryland 20705 4400 Powder Mill Road Beltsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician/ drac CIA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 27 NO 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tes Yes 26. Place of Death (Check only one) 25. Was case referred to medical B B examiner? Other: Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 2 7 No 1 Inpatient ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manger of Death 28b. Time of 28c. Injury at 5 Pending Natural 1 ☐ Yes 2 ☐ No М Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cau only one 29d. Date signed (Month, Day, Year) 20115 Name and address of person who completed cause of death (Item 23a) (Type, Print) LLANT FOX LANE Date filed (Month, Day, Year) State MAR 30

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery For State
Registrar MFND#19aperFH. 3-31-11; PMV, MCO Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 25 Physician/ Month Howard AllTh 10:35 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hobrow ROCKVIIIC Montgomer 9 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Months Days Hours Min Director 216-16-0306 89 Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Montgamery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 218 Spring Avenue 20850 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: "natural" 3 🗆 Widowed 4 🗆 Divorced Completed Black Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 6th Dept of Parks & Recreation City of Rockville Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Allen T. Howard, Sr. Lucy Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a ant: If item 27 is Allen T. Howard, III 8959 Centerway Road, Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery: 04/04/11 Crownsville, MD 21. Signatur f Funeral Service 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or conshock, or heart fallure. List on ations that caused the de sease, or com th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line. Immediate Cause (Final estiva Heart Failure Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death detached g Unknown g Unknown P.O. nis certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completed filled in by the funeral (Month, Day, Year) Natural 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Tertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) Temlen 03/25/2011 aupon CRNP R172412 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S + . E. JE FERSON ROIKVILLE IMD 20852 TIMLIN 1801 Alyson 31. Date filed (Month, Pay, Year) WAR 3 0 2011 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Beatrice Hempfling 28° 2011 3:58 рΜ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Y Aug 26, 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 1 □ M 2 F Months Days Hours Year 1918 404-07-3765 Director 92 Kentucky Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD 1 Ves 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1509 Red Oak Drive 20910 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after Specify: White 1 ☐ Yes 2 No Specify: If Yes Give "natural", Completed 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 Is and Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other transcone. ပ James J. Probus Ruth Lillian Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James F. Hempfling/Son 1509 Red Oak Drive, Silver Spring,MD 20910 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Calvary Cemetery April 4, 1 🛣 Burial 2 □ Cremation 3 🛣 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Louisville, KY 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final nset and Death Ph sician/ Cerebrovascular Accident disease or condition resulting in death) vears Medical Due to (or as a consequence of Examiner Arteriosclerotic Cardiovascular Disease years Sequentially list conditions. ri any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events ng physician and as the burial-trait Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No Month Year Pregnant at time of death Day Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Essential Hypertension, Hyperlipidemia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy performed? death? Yes 2 K No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 XYes 2 🗌 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 1 🖺 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending 2 Accident 1 🗌 Yes Investigation pleted filled in by the ☐ Suicide ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D12121 March 29, 2011 10 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) 3929 Ferrara Drive, Silver Spring, MD 20906 George F. Sengstack, MD31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 3 0 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March JANET S. HEINBOKEL 1332 PM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Easton Faston Talbot Memoria Hospital at Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Months Days 86 1272871924 CALTFORNIA Director 188-36-5393 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important: If item 27 is marked of ther than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7428 KEVIN AVENUE 21601 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 LEO SCOTT HARRIETT BAXTER 19a. Informant's Name/Relationship (Type, Print) HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK H. HEINBOKEL 7428 KEVIN AVE., EASTON, MD 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION 03/25/2011 1 Durial 2 Cremation 3 Removal from State STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury 00 that initiated events resulting in death) Last Due to (or a)s a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year □ Pregnanτ□ Unknown ☐ Yes ∠ ∟ ☐ Unknown Part II. **Other significant conditions c**ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 T No 3 ☐ Probably 4 ☐ Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗆 No 1 Yes Be 25. Was case referred to medical examiner?
1 ☐ Yes 24 No 26. Place of Death (Check only one) Hospital: Other: မ 1 € Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work: 1 ☐ Yes 2 ☐ No Accident Suicide Investigation within 24 hours after death

To the Funeral Director; A

completed filled in by the i 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) iMI 30. Name and address of person who completed 🛭 ause of death (Item 23a) (Type, Print) 31. Date filed (Month. Dav. Year) State MAR 25 Registrar

			For State Registrar	State of Ivial ylar		rtificate of		ieritai i iy	Reg. No		11010			
Physician /Medical			1. Decedent's Name (First, Middle, Las				2			7, 2011	3. Time of Death			
			Edward 4a. Facility Name (If not institution, giv	Adam e street and number)	Ha	4b. City, Town, o	r Location of Death	Mar.		. County of Death	3:30 A M			
	Examin	er	24050 Porters Cr	eek Lane		St. Micl	naels			Talbot				
	Funeral Director		200 00 0100	ex X M 2□ F 7. Age (In yrs. 72	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 8-16-1	th ay, <i>Year</i> .938	9. Birth Cou V	place (State or Foreign ntry) W •			
	yland now		Usual Residence of Decedent 10a. State 10b. County		ty, Town or Lo						10d. Inside City Limits			
	e Mar	ctor	Md. Talbo	t	St.	Michaels				(110)	1 ☐ Yes 2 No			
	with the	Funeral Director	10e. Street and Number 24050 Porters Cr	ook Isno		10f. Zip Code 2166	2			itizen of What Cou	nury ?			
	death	nera	11. Marital Status	12. Was Decedent Ever in U	.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		14. Race - Ameri Black, White,				
900	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examinum must be rediffed at	þ	1 ☐ Never Married ※ Married 3 ☐ Widowed 4 ☐ Divorced	1X Yes 2 No If Yes, Give Marin Year or Dates:	es	1 □Yes 2X No	Specify:			Specify: Wh	nite			
15-0	n 72 ho "natu	lete	15. Decedent's Ed (Specify only highest gra	ide completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	oation during most of work d)	ing	16b. l	Kind of Business/Ir	ndustry			
212	d withii giene. er than	Completed	Elementary/Secondary (0-12) 12	College (1-4or 5+) 5+		lanager			Manı	ufacturir	ng			
Maryland 21215-0036	be od o	To Be C	17. Father's Name (First, Middle, Last, Paul Hamman					(First, Middle, Maiden Surname) Harness						
	nit. Pages 1 and 2 should artment of Health and Men ortant: If item 27 is marke Injury or other traumatic.		19a. Informant's Name/Relationship (Ann Bradt Hamman	**	,		and Number or Rui		/kd. 21663					
Baltimore,	Pages 1 and 3 nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specie	removal from State Ros	Place of Disponentery, cresedale	osition (Name of matory or other plac Cemetery	ce) !	Date 2011		tinsburg				
Balti	20a. Method of Disposition 1 Disposition 1 Disposition 2 Disposition													
	Physician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the dear one cause on each line.	th. Do not en		ng, such as cardiac				Approximate Interval Between Onset and Death			
1	Examiner	L	Sequentially list conditions,	Due to (or as a consect										
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consex	frie ioc 3th.									
90,	rificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a consec	quence of):									
68760,	ificate g physi is the b	edical		d			-							
O. Box (To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	☐ Ectopic pregnand ☐ Other (specify) _	су			23d. Date of deli Month	very Day Year			
ds, P.	ires that t signed by d be detac		Part II. Other significant conditions	contributing to death but not res	sulting in the i	underlying cause giv	ven in Part I.			/	the cause of death?			
Records,	e law require has been si je 2 should b	Completed by						24a. Wa	s an opsy formed?	prior to o	topsy findings available completion of cause of			
tal	slcian: The certificate hi		25. Was case referred to medical				26. Place of Dea	1 □ Yes	2.EN	√o 1 □Yes	211No			
f Vi	nyslcia nis cer direct	lo Be	examiner? 1 ☐ Yes 2 ☐ No	Hospitaf: 1 ☐ Inpatient 2 ☐] ER/Outpatie	ent 3 □ DOA Oti	hor:			6 ☐ Other (Spec	cify)			
o uc	ding Ph h. After th funeral	lion:	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time Injury	Wo	ry at rk?]Yes 2 □ No	28d. Describe	how inj	ury occurred				
Division of Vital	or Atten after death Director: I in by the	ertifical	1 Yes 24 No											
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manger stated.	owledge, dea	ath occurred at the tinvestigation, in my	time, date and place opinion, death occu	and due to the	e cause e, date a	e(s) and manner as and place, and due	s stated. to the cause(s)			
	To the within To the comple	Me	29b. Signature and title of certifier	Trush			se number		29d. [Date signed (Month	n, Day, Year)			
	STVA		30. Name and address of person who Matthew J. Fisch				te 1 EAst	on, Md.	21	601				
		ate rar	31. Date filed (Month, Day, Year) NAR 3 1 2	32. Aegistrar's Sign	mår sen									

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2811 March 11 38 M DOROTHY W. HAGNER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The Memorial Haspital Easto ialbot Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min. Director 220-18-8318 85 0170771926 MARYLAND Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director **EASTON** 1 💢 Yes 2 🗌 No TALBOT MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 21601 700 PORT STREET, COTTAGE 216 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc ð 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) STELLA CZAJKOWSKI JOSEPH WLADKOWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 HOPKINTON ROAD, CONCORD, NH 03301 DAVID C. HAGNER / SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 XCremation 3 Removal from State CHESAPEAKE CREMATION
CENTER 03/28/2011 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 Duamma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DAYS Immediate Cause (Final Physician/ RENAL FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner COPD DAYS Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Who Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 10 Other: Certificate; To within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🔲 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🖿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Raevelow D0066441 MARCH 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASHINGTON STREET EASTON MD RAMESH 2195 10 31. Date filed (Month, Day, Year) State MAR 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Anne Koch Harter Physician/ March 25^{Day} 7:44 P M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Anne Arundel Examiner Anne Arundel Medical Center Annapolis 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 6, 9. Birthplace (State or Foreign **Funeral** Country) Missouri 226-84-8330 1 M 2XX Months Days Hours Year 64 **Director** 1946 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Anne Arundel Arnold 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 463 Colonial Ridge Lane 21012 U.S.A. or items 23a 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White "natural", Specify: 3 Widowed 4XDivorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Consultant Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Rosemary White Marvin Koch 19a. Informant's Name/Relationship (Type, Print)
Michele Jackson/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3746 Chateau Ridge Court Ellicott City, MD 21042 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John's Cemetery 20a Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Ellicott City, MD 4/1/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner at Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death by signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s has autopsy performe death? 2 🗌 No 1 🗌 Yes 1 Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral place of the funeral completed filled in by the funeral completed filled in the funeral completed filled in the funeral completed filled in the funeral completed filled in the funeral completed filled in the funeral completed filled f Natural 5 Pending work Accident 1 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway Annapolis, MD 21401 31. Date filed (Month, Day, Year gistrar's Signature State 9 2011 MAR 2 Registrar

Please Type or Print in Black Indelible Ink. Epsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Hitchc 1525 PM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EIKton er Union Hospita 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min. - 3402 1 M 2 🗆 F Hours MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director MD ElKton Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) government panitation lown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ျ Hitchcock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lane Margaret Hitchcoc WITE Newark .aurel 20a. Method of Disposition 20b. Place of Disposition (Name of United Crematory or other plate) 1 Burial 2 Cremation 3 Removal from State 03/29/2011 Newark, DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility Strang + Feeley Family Funeral Home 21, Signature of Euneral Service Licensee Road, Newark DE 19702 chmans 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ACUTE RENAL FAILURE Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner SEPTIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of Acute Tubular Necrosis use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records. Completed To the Hospital or Attending Physician; The law req 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Tes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director: After this of Death 27. Manne 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) MARCH, 27, 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 BOW STREET, EIKTON, MD 21921 HAMADEH, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 3.0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2011 ALICE BEATRICE JONES HEMSLEY 2:30 A M MARCH Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MEDICAL CIVISTA CENTER LA PLATA CHARLES Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 214-28-8805 1 □ M 2**X** F 89 Hours OCTOBER TO, 1921 MARYLAND Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director CHARLES 1 X Yes 2 No MARYLAND NEWBURG 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral UNITED STATES 12760 SHILOH CHURCH ROAD 20664 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 \square Never Married 2 \square Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: BLACK 3 X Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 7TH GRADE (0-12) College (1-4 or 5+) FOOD SERVICE COOK Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) AZARIAH JONES JULIA SILAS JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12750 SHILOH CHURCH ROAD, NEWBURG, MARYLAND 20664 ODESSA M. HEMSLEY / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State SHILOH CHURCH CEMETERY APRIL 2,2011 NEWBURG, MARYLAND 4 Donation 5 Other (Specify) on ture of Funeral Servic / icenses THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN LADIA C. THORNTON JOHNSON M00583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or nepiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit seautince of resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Hospital 1 Tyes 2 Tho မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes Natural 5 Pending 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined 29a. Certifier 🗣 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner To the bes of my knowledge, death 29b. Signat 29c. License number D-2062 address of person who completed cause of death (Item 23a) (Type, Print) GEORGE ATHEN. M. D. PEMBROOKE SQUARE 31. Date filed (Month, Day, Year) 32. Registrar's Signature 20603 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4204 Yarnell Court Bowie Prince George's 9. Birthplace (State or Foreign Country)
Germany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 M 2 D F Days 10/06/1930 Director 125-24-4196 80 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Bowie 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4204 Yarnell Court 20715 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes 2 X No 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify. White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Independent Contractor 4 Systems Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Schutze Gunther Jacobson Louise injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is any injury or 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mearle E. Jensen/Spouse 4204 Yarnell Court, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 03/26/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ginset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Completed 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autons death? this certificate ! 1 Yes 2 No Yes 2 L To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 100 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No 2 Accident M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier a

Baltimore, Maryland 21215-0036

Box 68760

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Records,

Division of Vital

31. Date filed (Month, Day, Year) State Registrar

60. Name and address of

TENTENTEVE

DEFENSE HWY ANNAPRIES H.D. 21401 32. Registrar's Signature

ompleted cause of death (Item 23a) (Type, Print)

LIGHTFOUT-TAYLOR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ . 2011 March 25 8:00 P Jahn Medical William Simon 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince Georges 11804 Montague Drive Laurel . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Months Days Hours Min. Oct 1943 Director 082-34-1996 67 New York Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl 1 Yes 2X No Maryland 1 4 1 Prince Georges Laurel 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral Page 1 and 2 should be filed within 72 hours after death with 11804 Montague Drive USA 20708 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes
1 Yes, Give 1 9 5 7 9 5 7 9 6 5 Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. "natural" 3 X Widowed 4 Divorced Specify: Completed White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Driver Trucking of Health and Mental Hygie f item 27 is marked other r other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maria E. Bruno William Jahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Bonnie Logan-Fiancee 11804 Montague Drive, Laurel, Maryland 20708 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Washington Crem March 27,2011 Laurel, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Inc. Fleck Funeral Home, Inc. 7601 Sandy Spring Rd., Laurel, Maryland 20707 MOIZ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) MONHE Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying
Cause (Disease or linjury Due to (or as a consequence of, attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year cate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

• Funeral Director: After this certificate has leted filled in by the funeral director, page 2 s autopsy performed 1 ☐ Yes 2 No Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes No No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier

CHMH

Registrar

DHMH 17 Rev 7/2009

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person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Johnston Month <u>8:1</u>5P [™] March 25. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Genesis Elder Care La Plata Charles 9. Birthplace (State or Foreign Country) Washington DC 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Date of Date (Month, Day, Year)

1 26,1935 **Funeral** 1**X**] M 2 □ F Months Days Hours **Director** 577-48-4048 Ju<u>ne</u> Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Charles La Plata 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6150 Ripley Way 20646 USA 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. White 3 X Widowed 4 ☐ Divorced Specify Completed Page 1 and 2 should be filed within 12.1.2.... Page 1 and 2 should be filed within 12.1.2.... thrent of Health and Mental Hygiene. thant: If item 27 is marked other than "natur Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Federal Govt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julian Avala Johnston Ruth P. VanStone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Gibson/Niece 8601 Temple Hill Rd. #35, Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 TCremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Crem.3/30/11 Charlotte Hall, MD M00945 Signature of Funeral Service Licens AREHART-ECHOLS FUNERAL HOME, PA. 4 a 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respectively. Such as cardiac or respectively. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, robably 4 🗆 Unknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 28c. Injury at Certificate: 28d. Describe how injury occurred work? Natural Accident injury 5 Pendina 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signaty 0620 address of pe who completed cause of death (Item 23a) (Type, Print) MBGTI 20603 31. Date filed (Month, Day, Year, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jennie Ethe1 Jones APP11 2011ª 2:33 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park USA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 579-40-0167 1 🏝 M 2 🗆 F Days Hours August Day2 2ar) Director 1925 $\overset{Country)}{\mathsf{VA}}$ Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10b. County "natural", or items 23a or 28a-f sho idical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits VA Richmond tH Yes 2 ☐ No 10f. Zip Code 23224 10g. Citizen of What Country? 10e Street and Number 1701 Dinwiddie Avenue Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Black Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 2 College (1-4 or 5+) Private Duty Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John R. Branch Fannie Lockett 19a. Informant's Name/Relationship (Type, Print) Maceo M. Jones, Sr./ Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1701 Dinwiddie Avenue Richmond VA 23224 20a. Method of Disp ition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🔼 Cremation 3 🗆 Removal from State Southside Crematory 04/14/2011 Richmond, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Dunn & Sons 5635 Eads St. NE Wahsington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician astrointestinal disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any leading to immedicause. Enter Underlying attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events evosclerohic Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been sral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျှ Other: 1 Tes 2 1 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide within 24 hours after deatl

To the Funeral Director:

completed filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (*Month*, *Day*, *Year*). 29b, Signature and title of cestifier 00060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHMINA HMED 30 Sail University Silver Slow 31. Date filed 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ March 27 1:15 p^M Virginia S. Kitchen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hillhaven Nursing Home Adelphi Prince George's 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan. 23 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 577-03-8265 **Director** D.C 916 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 TV No Silver Spring Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3757 Glen Eagles Drive 20906 USA death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 hours after Specify:White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic even 2 James Rosser Smith Sadie Gooding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay Kitchen Robinson/Daughter 3757 Glen Eagles Drive, Silver Spring, MD 20906 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1¾ Burial 2 ☐ Cremation 3 ☒ Removal from State cemetery, crematory or other place) April 2011 4 Donation 5 Other (Specify) Wakefield, VA Wakefield Cemetery .22. Name and Address of Facility. Francis J. Collins F 500 University Blvd. 21. Signature of Funeral Service Licensee Funeral Home d. W., Silver Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. Failure to Thrive disease or condition Medical resulting in death) **Examiner** Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir ransit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 X No ō Month Day Year the signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Osteoarthritis Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 2 certificate 2 No 1 Yes 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🔀 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 🛭 Natural 5 Pending work Accident 1 Yes 2 No Investigation the 1 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10 D51897 March 28, 2011 30. Name and address of person who completed cause of death (Item 3a) (Type Print)
Njideka Udochi, MD 9055 Chevrolet Drive, #100, Ellicott City, MD 21042 MAR 29 2011 State arket

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener (For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ March 27, J. Kaminski 5:25 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01nev Montgomery Birthplace (State or Foreign Country)
 NV Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month Day, Year, April 18, Hours 1 3 M 2 1 Director 93 071-09-4125 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15320 Pine Orchard Drive, #3A 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Armed Forces? 1X2 Yes 2 □ No Black White etc. 0. 1 Never Married 2 Married Completed by Yes Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: and Mental Hygiene. is mar! ed other than "ratural", 3 ☑ Widowed 4 ☐ Divorced Year or Dates. WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Budget Director Justice Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John J. Kaminski Rose Scarveski permit. Page 1 and 2 should c Department of Health and Mem Important: If item 27 is mar e any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18210 Bluebell Lane, Olney, MD 20832 Michael J. Kaminski/Son 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part 1. Arter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ASPIRATION PNEUMONIA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ansit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last the burialphysician Physician/Medical attending pl I for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) been signed by the s 1 ☐ Yes 2 L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an page 2 performed Yes 2 1 Yes 25. Was case referred to nedical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 II No 1 🗌 Yes ျု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this leted filled in by the funeral di 27. Manner of Death Certificate: 28a, Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical (29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 only one) 29b. Signature and title of certifie 29c. License number D 59418 MARCH 28,2011 10+1 Dawring MD

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

Division of Vital

18101

Prince Philip Dr. Olney, Md. 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Adewunni

vemi

nonth, Day, Year,

MAR 29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEB. RAYMOND ROSCOE KELLY 15:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE COMMUNITY HOSPITAL CHEVERLY PRINCE GEORGE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**X**XM 2 □ F Months Days Hours Min WASH., Director 75 577-46-5970 Yrs DC Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits r 28a-f s notified MD PRINCE GEORGE CAPITOL HEIGHTS 1 X Yes 2 No 10e. Street and Number è 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 529 DRUM AVENUE U.S.A. 20743 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24.4No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2XX Married δ 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. 12TH GRADE College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important; If item 27 is marked other t any injury or other traumatic event, the once. **PRESSER** IVORY CLEANERS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည UNKNOWN ANNABELLE KELLY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA E. KELLY--WIFE 529 DRUM AVE. CAPITOL HEIGHTS, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2XXCremation 3 ☐ Removal from State LEE CREMATORY 2-25-2011 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MD 20735 22. Name and Address of Facility FINCKNEY-SFANGLER F. II. 21. Signature of Funeral Service Licenses 524 - 8TH ST., N. E. WASH.. DC 20002-5236 23a. Part 1. Enter the disease, or complications that caused the death. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ FATAL CARDIAC ARRYTHMIA disease or condition resulting in death) **Medical** Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year signed by t d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CEREBRAL VASCULAR ACCIDENT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗀 Yes 2 X No Other: မှ After this funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: . Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending neral Director: A I filled in by the fu Accident Investigation Suicide 6 🗌 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined within 24 hours an

To the Funeral D

completed filled in To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 039026 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UZO UNEGBU, M. D. 6323 GEORGIA AVE. SUITE 206 A WASHINGTON, DC 20011 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien P 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2<u>011</u> Physician/ March 28, p^M John 8:28 Gustave Kraemer Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery General Hospital 01ney 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug. 23, Year 1929 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Months Min. Country) D.C. 81 Director 579-36-1589 Yrs. Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDSilver Spring 1 Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3220 Ludham Drive 20906 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 x Yes 2 ☐ No If Yes, Give within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 33€ Widowed 4 Divorced Year or Dates. WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
s marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 Executive Vice President Mortgage Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ည Carl Rudolph Kraemer Josephine Waggaman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
hter 10143 Hobsons Choice Lane, Ellicott 21042, MD 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st
Department of Health a
Important: If item 27 is
any injury or other trai Ellen Patricia Chahanovich/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. University Blvd. W., SIlver Spring MD 20901 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease years Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) tending physician and ruse as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year g 🗌 Unknown 9 Unknown ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ᡮ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? has performed? 2 🗆 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No 1 Yes Other: 1 ☐ Inpatient 2 B ER/Outpatient 3 ☐ DDA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu 1 Yes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the pasts of examination arrange investigation, in this opinion, seal recounted at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) D08381 March 29, 2011 30. Name and address eted cause of death (Item 23a) (Type, Print)
MD 18111 Prince Philip on who comp Avrunin, MD Drive, Olney, MD 20832 Benjamin 31. Date filed (Month, Da State 32 Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

State of Maryland / Department of Health and Mental Hygiens State Registrar Amend#11pfh4/5/201&cdohrb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Elizabeth King March 27. 2011 11:07 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8600 Mike Shapiro Drive Apt 715 Prince George's Clinton 1 4 1 Social Security Number If Under 1 Year If Under 24 Hrs Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😿 F Months Days Hours Min. $\int_{an}^{Month} 9, 1932$ 79 North Carolina 218 52 1457 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Maryland 1 Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 8600 Mike Shapiro Drive Apt 715 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 Williams Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify. **Black** 3 XWidowed 4 ☐ Divorced Specify. Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important. If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Environmental Control Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Scott 0. Cox Louise Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila King (Daughter) 15810 Penn Manor Lane, Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Lee Crematory Clinton, MD April 4, 2011 Signature of Juneral Service L 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Ent a the dis-shock, or yeart failur complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line Interval Between Immediate O lise (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Enotic Corynamy Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Dilated Candwingorath Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autonsy performed Yes 2 N 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending work? 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certify durse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number D0055120 mis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD PALMER MD 1328 Southern Avenue SE Swite 310 Washinglon DC 20032 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Monthar 20^{Day}2011 Year 2:30 AM Kelby Patricia Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany 312 Mountain View Drive Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) OH Funeral 1 □ M 2 □**x** Days Mah 20 1938 270-34-8577 73 Director Usual Residence of Decedent 28a-f show 10b. Count 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Allegany Cumberland 1 Xes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Medical Examiner must be 23a Funeral 312 Mountain View Drive 21502 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white "natural" Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the professional singer Entertainment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edna Guertal William Kelby 19a. Informant's Name/Relationship (Type, Print)

Judy Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 21502 Executo Department of Health a Important: If item 27 is any injury or other trat 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 3/22/2011 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Scales etti Fruiteral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . E. e. th. 13- as ., or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ disease or condition resulting in death) ACCINOMA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as the ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ò Month Day Year detached ģ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by or Attending Physician: The law requires 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 1 🗌 Yes 2 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 X Natural 5 Pending 1 Yes 2 🗆 No 2 Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Court Co MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JELIK M.D. 12502 WILLOWBPMOK

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ${\tt Mar}^{\tt Month}$ 2011 Virginia D. Lunsford 11:45p ^M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ceci1 109 Spring Hill Rd. Rising Sun Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 TITT 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Year 931 Months Hours June 16 1 □ M 2 🗓 F 234-54-8858 79 WV Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗆 Yes 2 💢 No MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 109 Spring Hill Rd. 21911 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Abraham Maynard Melissa Staten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Johnson / Daughter 1006 West Old Philadelphia Rd. North East, MD 21901 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) West Nottingham Cem. 4/1/2011 Colora, MD Name and Address of Facility
T. Foard Funeral Home, P.A.
II S. Queen St. Rising Sun, 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Unknown. Physician/ ances disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Dualto (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the sahould be detached to g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 🗹 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗖 only one) 29b. Signature and title of optifier 29c. License number 29d. Date signed (Month, Day, Year) 3.29.2011 D0023322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S SACH DEU MD, 126 A, E truel S Elham MD 21921. 126 A 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier@ () 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ MARCH 28 2011 WILLIAM EMORY LANE **P** M 3:15 Medical 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death QUEEN ANNE'S 105 SHIPPING CREEK ROAD STEVENSVILLE Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Year) 1921 1 **☑** M 2 □ F Months SEPT. Day Ye Hours Min 89 Yrs MARYLAND 220-28-0200 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State the Maryland notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No QUEEN ANNE'S MARYLAND STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral with. 23a 105 SHIPPING CREEK ROAD UNITED STATES 21666 items 2 death v 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. within 72 hours after Maryland 21215-0036 WHITE 1 Yes 2 No Specify Specify 3 X Widowed 4 □ Divorced "natural" Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the FARMER **FARMING** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Department of Health and Ment. Important; If item 27 is marked any injury or and WILLIAM STANLEY LANE ELIZABETH PALMER 19a. Informant's Name/Relationship (Type, Print) 103/aSHADPINGetCREEKerROADPoutSTEVENSVELLEAte, MARYLAND DONALD LANE/ SON 21666 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of STEARERS Vertebror other place) 20c. Location - City or Town, State APRIL 1. 1 X Burial 2 Cremation 3 Removal from State CEMETERY 2011 STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) FELLOWS AND RELFENBEIN, & NEWNAM FUNERAL HOME, P.A. 21. Signature of Funeral Service Liver 106 SHAMROCK ROAD, CHESTER, MARYLAND, 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph_sician/ (onlegge 2MR) disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or iinjury
that initiated events Due to (or as a consequence of) -transit and Due to (or as a consequence of) physician all s the burial-t resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending pl IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death] Yes 2 □ No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> pe Completed 1 Yes 2 No 3 Probably 4 Wunknown page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? After this certificate ! 2 X No 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 🗌 Yes 5 Pending 2 No 2 Accident
3 Suicide
4 Homicide Investigation Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined after City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner: To the best of my knowledge 29b. Signature and title 29d. Date signed (Month, Day, Year) nd address of person who completed cause of death (Item 23a) (Type, Print) Dueny JEFFAREY Connentle 2540 21617 31. Date filed (Month trar's Signature State 201 9 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 28 201 Year 7:05 MARCH A M ROBERT MURRAY LAIRD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S CENTREVILLE 603 SYMPHONY WAY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months 1 **X** M 2 □ F Days Hours Min. MARCH 25, 1922 MASSACHUSETTS Director 89 031-12-3150 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director CENTREVILLE 1 X Yes 2 No **OUEEN ANNE'S** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 603 SYMPHONY WAY USA 21617 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) T.AW ATTORNEY 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of ပ MARGUERITE F. ATWOOD ELVET E. LAIRD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 603 SYMPHONY WAY, CENTREVILLE, MD 21617 PATRICIA ANN HILL/ DAUGHTER 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗌 Burial 2 🗶 Cremation 3 🗌 Removal from State cemetery, crematory or other place)
CHESAPEAKE CREMATION MARCH 29. STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
408 S. LIBERTY ST., CENTREVILLE, MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Cancer of larynx Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and -transit death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 attending IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page 2 s 2 No 2 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner' Other: 2 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and jitte of certi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 115 Sallitt Drive, Suite E Stevensville, MD M.D. onick 32. Registrar's Signature State Registrar

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Division of Vital Records, P.O. Box 68760,
i the Hospital of Attending Fuysician; The law requires that the death certificate be executed thin 24 hours after death
the Funeral Director: After this certificate has been signed by the attending physician and
mpietely filled in by the funeral director, page 2 should be detached for use as the bunal - transit

			I- For State Registrar		tificate o		id Wientan		eg. No.		
Phys Medical Exa		n/	Decedent's Name (First, Middle,Last)		т.,			2. Date of Deat Month March 24,		3. Time of Death 2159 hrs	
ijediodi Exa			Gregory Lucious 4a. Facility Name (if not institution, give street and numb		Jr.	•	or Location of Dea		4c. County of Death		
Former			4411 23rd Parkway 5. Social Security Number 6. Sex 7.	Age (In vrs. la	est hirthday)	Temple Hi		Irs. 8. Date of Birt	Prince George th(MM/DD/YYYY) 9. Bir		
Funer Direct		unk 1XM 2 F 31 Yrs. Months Days Hours Min. July 29, 1979									
v any		-	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Local					10d. Inside City Limits	
Aaryland 28a-f show	t once.	혖	Maryland Prince George's 10e. Street and Number		Clinto	n T10f. Zip Code		110	0g. Citizen of What Cou	1 Yes XX No	
th the Mar	must be notified at once.	Dire	8204 Anaio Court			20735			United State	25	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene, 27 is marked uther than "natural", nr items 23a nr 28a-f sh	must be	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Deced Armed Forc 1 Yes		lf /	es, specify Cuba	an, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	White, etc.	can Indian, Black,	
urs afte	9	ā	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade or Dates)	completed)	16a. Deceder	nt's Usual Occup	ation (Give kind o	of work done	Specify: B	ack ndustry	
136 hin 72 ho e. than "na	the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4	ost of working li curity Off	icer	etired)	Security				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked utther than	it, the M	Be Con	17. Father's Name (First, Middle, Last) Gregory L. Lawton, Sr.					me (First, Middle, M 311 Lawton	Maiden Surname)	ame)	
212 hould be ad Ment is mark	itic ever		19a. Informant's Name/Relationship (Type, Print)	`					nber, City or Town, State	, Zip Code)	
and 2 sho fealth and item 27 is	traum	ŀ	Gregory L. Lawton, Sr. (Father	20b. F	Place of Dispos	sition (Name of c	urt, Clint emetery,	con, MD 20	20c. Location - City or	Town, State	
Baltimore, permit. Pages I as Department of He Important: If ite	r other		1 X Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specify:	State	eritage (emetery	3/	/31/2011	Waldorf, MD		
Balti permit. Departm Imports	injury 1	Ī	21. Signature of Funeral Service Licensee	101555			ss of FacilityLec		ome,Inc 6633 (Old Alexandria	
Physicia		7	28a. Part I. Enter the disease, or complications that caus failure. List only one cause on each line.	ed the death.	Do not enter t	the mode of dyin	g, such as cardiad	or respiratory arro	est, shock, or heart	Approximate Interval Between Onset and	
	Immediate Cause (Final disease or each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot wounds (2) of head (1) and chest(1) Due to (or as a consequence of):									Death	
	ı	<u>_</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a co	nsequence of	D):						
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last								
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50, te be execut tysician and	burial	Medical	IF FEMALE: 23c. If yes, out	come of pregr	nancy				23d. Date of deliver	,	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.	for use as the		23b. Was decedent pregnant in the past 12 months?	t at time of dea	2 Fe	etal death 3 ther (Specify)	Ectopic preg	gnancy	Month I	Day Year	
O. BC It the dea	장	문	Part II. Other significant conditions contributing to de		esulting in the	underlying cause	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?	
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F Vita Physicia r this ce	냚	To Be	Tes 2 No		ER/Outpatien		Other Nur	•	Residence 6 Othe	r: Scene	
ON O	the funeral	ţį	27. Manner of Death 1 Natural 5 Pending Mar 24, 20	ay Year)	2135 hrs	· · _	Yes 2 Voik?	Subject sho	, ,		
Divisi tal or Att rs after de	filled in by	Certification:	Suicide 6 Could not be	f Injury - At ho		eet, factory, office	building, etc.		Street and Number or Ru State) rkway , Temple Hills,		
Di To the Hospital within 24 hours a To the Funeral I	completely fil	Medical Co	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of one)	f my knowledg	ge, death occu			ind due to the caus	se(s) and manner as stat	ed.	
To To To	con	Mec	29b. Signature and title of certifier	ed.			nse number		29d. Date signed (Mo	nth, Day, Year)	
			Theodore M. Kru	9 11	y MI	0.0	C.M.E.	غاديارا	March 25, 2011		
233			•	Medical E		111 Penn S	Street, Baltimo	ore, MD 2120	1		
		ate rar	31. Date filed (Month, Day, Year) 32. Regi	strar's Signatu	ire frank	2					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Frank Longo March 27 12:50 P M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mechancsville St. Marys 26619 Lawrence Adams Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex . Age (In yrs. last birthday) Funeral Jan 23, 1928 Italy XX M 2 D F 081 24 0040 83 Director Usual Residence of Decedent 23a or 28a-f show ist be notified at 10c. City, Town or Location 10d. Inside City Limits 10b County 10a. State within 72 hours after death with the Maryland Director Maryland St. Mary's Mechanics ville 1 Yes 2 XNo 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral must t 26619 Lawrence Adams Drive United States 20659 items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. "natural", or 1 Never Married 2 XMarried Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 1 and 2 should be filed within 72 nouses. White 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Finisher Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret Miguel Longo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 26619 Lawrence Adams Drive Mechanicsville, MD 20659 Teresa Hickman (Daughter) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 Donation 5 Other (Specify) Resurrection Cemetery April 1, 2011 Clinton, MD 21. Signatur of Funer & Service Lice 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Corona Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner 000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a conseque and -transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed r has this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical or Attending Physician; 26. Place of Death (Check only one) Be 1 🗌 Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) ည within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year, injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident M Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and the of cer 29d. Date/signed (Month, Day, Year) 29c. License number person who completed cause on death (Item 23a) (Type, Print) 203A Da Suto 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death March 23, 2011 Physician/ Helen Dorothea Losiewicz 2:20 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Mt. Airy Kline Hospice House Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Year 1926 1 M 2 X F Months Days Hours July 19, New Jersey 84 150-16-8375 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits death with the Maryland Director Keymar Maryland Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21757 Funeral 12906 Woodsboro Pike USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 be filed within 72 hours after 1 ☐ Yes 2 X No Specify: Yes, Give Specify: white "natural", 3 Widowed 4 Divorced Completed Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Human Resources Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Knoll ည Walter Michelus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12906 Woodsboro Pike, Keymar, MD 21757 Edward Losiewicz, husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 3/26/2011 Taneytown, MD St. Joseph Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licens 22. Name and Address of Facility 22. Name and Address of Facility Myers—Durboraw Funeral 136 E Baltimore St, Taneytown, MD 21787 Home Part I. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onet and Death mmediate Cause (Final Physician/ 0 an disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending hybicidan and Cause (Disease or linjury that initiated events tran-Due to (or as a consequence of): resulting in death) Last attending physiclan a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death g Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 → Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 1 Yes 2 No Be completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🗀 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ other (SpeciHOSPICE Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 ☐ Yes 2 ☐ No after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) 31058 03/25 WJL 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Woods does 21798 COPPER MINE GENE 10200 RD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11895 For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RICHARD ARLEN LAIRD MARCH 153 M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 10001Co odian TENINSULD ocial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Hours 224-60-8074 75 (Month, Day, Year) 12/12/1935 Country) Director VIRGINIA Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director VIRGINIA **ACCOMACK** TANGIER 1 X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 23440 U.S.A. 16321 MAIN RIDGE ROAD ould be filed within 72 hours after death ond Mental Hygiene. marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) WATERMAN SEAF00D 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, RICHARD H. LAIRD MARGARET ELLEN CROCKETT permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DARLENE LAIRD / SPOUSE P.O. BOX 34, TANGIER, VA 23440 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/29/11 TANGIER, VIRGINIA LAIRD FAMILY CEMETERY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WILLIAMS FUNERAL HOME, 25046 PARKSLEY RD., PARKSLEY, VA 2342 Mllams 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Examin that the death certificate be executed burial-trar Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident 2 Accident
3 Suicide
4 Homicide the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D 48098 26/2011 0

State

Box 68760

Records,

Division of Vital

DHMH 17 Rev 7/2009

Registrar

100 €

CARROLL St. SALISBURY Md. 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARUMBUNATHANMD

amend item	#5 _:	Pleas, per fh, 03/29/11,	se Type or Pri	nt in Black arvland / D	k Indelil epartme	ble Inlent of F	k. Ens Iealth	sure Al	II Copie ental Hv	es Ar	e Leg	ible.	118	96	
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buria	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1								23d. Date of delivery Month Day Year				
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Division of Vital R To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificat completed filled in by the funeral director, pa	Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	be 280 Place of Inju	iry - At home, farm c. (Specify)			165 2	-	Bf. Location (City or Tox			r or Rural	Route Number	;	
E Hospita 124 hours 8 Funeral	Medical	(Check 2 Medical Exa	nysician: To the best of miner: On the basis of e urse Practioner: To the	kamination and/or in	vestigation, in	my opinio	n, death o	ccurred at th	ne time, date a	and place	e, and due	to the cau	se(s) and mann	er stated.	
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		30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Typ	pe, Print)	ر ا ر									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month March Katalin Meszarics 27 2:07 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)Hungary Min. Hours 1 M 2 52 F Dec. 21, Year 919 91 Director 577-58-9902 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location ortant. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director MD 1 Yes 2 🙀 No Montgmery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2807 Hathaway Terrace 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ₺ No Specify: If Yes, Give Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 12 Self-Employed Manicurist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gyorgy Fodi Maria Stircula 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Katalin I. Pataki/Daughter 2807 Hathaway Terrace, Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 ☐ Burial 2 😿 cemetery, crematory or other place) Cremation March 28 4 ☐ Donation 6 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signature of Fineral Solvi /e Licens Francis J. Collins Funeral Home Inc. University Blvd. W., Silver 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final enysician/ disease or condition VIS Medical resulting in death) Examiner Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialphysician sthe burial Physician/Medical Box 68760 nding p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death signed by the a d be detached f Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2. No မ 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury after death. Director: Af 2 Accident Investigation 1 🗌 Yes 2 🗌 No the within 24 hours after de To the Funeral Directo completed filled in by th Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 3/27/11 DO050410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip De chac. 31. Date filed (Month, Day, Year) State Registrar

State

Registrar

31. Date filed (Month, Day, Year)

MAR 29

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 5:20 Cary Lincoln Matthews P^{M} March 29, 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's College Park 9738 53rd Avenue If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1930 Kambridge, VA 1 🔀 M 2 🗆 F Hours Min. (Month, Day, 81 228-22-9357 Director February 12, Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Prince George's College Park Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20740 9738 53rd Avenue "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates. 1 Never Married 2 X Married by White 1 Yes 2 X No Specify Completed 3 Widowed 4 Divorced d 2 should be filed within 72 hours a nath and Mental Hygiene. n 27 is marked other than "natural er traumatic event, the Medical E. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **METRO** 12 Metro Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Claire Almond Douglas Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9738 53rd Avenue, College Park, MD 20740 Eunice T. Matthews / Wife 1 and 2 s f Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Fort Lincoln Cemetery 4/1/2011 Brentwood, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 PAG Royer> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Colon Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No page 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) nin 24 hours after death.

the Funeral Director: After this certific npleted filled in by the funeral director. Be examiner? Hospital Other: 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending 1 X Natural 5 Pending work?
1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 🖸 Certifying Physician To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The Date of the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examine (Check 3 Certifying Mai 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) of person who completed cause of death (Item 23a) (Type, Print) Ivan Ngang Zama, 9200 Basil Court, Largo, MD 20774 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ MOVVIS MARCH ZO/ 0211 A M IVIa Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL EASTON HOSPITAL ALBOI 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MAINE 1 □ M 2 🔽 F Months Hours Director 007-34-2860 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 29734 AUSTIN LANE 21601 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **TEACHER EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Page 1 and 2 should be THEODORE LEWIN FLORIDA COOK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 MARK E. MORRIS Son 29734 AUSTIN LANE, EASTON, MD 21601 Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CHESAPEAKE CREMATION CENTER 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 03/25/2011 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD Sign of Juleral Service Le FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 23a. Part 1. Enter the disease, or complication at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cau Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Section tially list expeditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate; 28b. Time of 28c. Injury at 1 Natural 5 ☐ Pending _ Investigation work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide n 24 hours after death e Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) he bath carp Edh R124198 21/1 8579 commerce Drive, Ste. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton MD 21401 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ THOMAS 114 (OM プも Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Arundel Anne Arundel Medical Center Annapolis Anne 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Min. Aug 22 Director Maryland 219-12-3929 83 1927 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 107 Stone Point Dr. Apt 164 21401 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2X Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced Year or Dates | 948 – 52 Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th 0 Personal Specialist Dept. of the Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Crawford McPherson Fredretha Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21401Muriel McPherson(Wife) Stone Point Dr. Apt 164 Annapolis, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 3-28-11 Baltimore, Md. 21. Signature of Funeral Service Licensee Winnlame Recese of &ciiiSons Mortuary, P.A. 821 West St. Annapolis, Md. 11004 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. terval Betweer Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending 1 Yes 2 🗆 No Investigation 6 Could not be within 24 hours after deal To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Praction of the cause of t 29a. Certifier (Check Signature and title of certifie U W VX who completed cause of death (Item 23a) (Type, Print) ENTA · Cle 441 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month LEENAN MURRAY ARBARA フull INNE 0752 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖊 F Hours 4,1925 October Massachusetts **Director** 032-16-4777 85 Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Anne Arundel Odenton 1 🗆 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1305 Wickell Road USA Odenton 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after deat th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner! 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White Specify. Completed 3 Midowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Director of Social Services Medical Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic eveni once. 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Francis Keenan Helen Margaret Ormond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Susan Murray/ Daughter 1305 Wickell Road Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🕅 Cremation 3 🗆 Removal from State Baltimore Washington 3/28/2011 Laurel, MD 4 Donation 5 Other (Specify) . Signature of Funeral Se 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician mita Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence oi): attending physician and for use as the bunal-transit Due to (or as a consequence of) Physician/Medical certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown that the death Month Day Year the tate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? Yes 2 Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 Tyes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours To the Funeral Completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certif Ta Ly 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), NNAPOLIS MDZULUI CHAG N M m 31. Date filed (Month State Registrar

DHMH 17 Rev 7/2009

Box 68760

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Division of Vital

State of Maryland / Department of Health and Mental Hygiene \(\begin{align*} \begin{align*} \text{ O } \\ \text{ Department} \\ \text{ O } \end{align*} \) 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Henry McMullen P^{M} March 2011 1:00 Medical 4a. Facility Name (if not institution, give street and number)
Anne Arundel Medical Center 4b. City, Town, or Location of Death Examiner 4c. County of Death Annapolis Anne Arundel 8. Date of Birth (Month, Day, Yea Sept. 23 Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Days 214-38-6608 Hours Year) 81 **Director** 1929 Maryland Usual Residence of Decedent 28a-f shor 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis Examiner must be notified 1 Yes 2 X No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 749 Red Cedar Road 23a Funeral 21409 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. or à 1 Never Married 2 Married ☐ Yes 2 🔀 No within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give "natural" 3 Divorced 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. sant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Manager Seafood Market Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည William F. McMullen Emma Dorothy Pieper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other tra Nancy McMullen/wife 749 Red Cedar Road Annapolis, Maryland 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Baltimore Crematory 3/31/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Funer John M. Taylor Funeral Home Signatur n/ce Licensee 22. Name and Address of Facility 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Raspirator Onset and Death Physician Medical resulting in death) Examiner on Chroni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Sepsis The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Abscess Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) detached 1 ☐ Yes 2 L 9 ☐ Unknown the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, is To the Hospital or Attending Physician: 25. Was case referred to pedical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 욘 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29d. Date signed (Month, Day, Year) 2011 30. Name and address of pe ause of death (Item 23a) (Typ MI Annetvundel AbW 420 ounce State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienefor State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month Elizabeth Marie Marcalus March 27 4:59 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea June 5. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 TYF Months Days Hours New York 139-26-5846 76 **Director** 934 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Anne Arundel Edgewater 10e, Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 3640 Fontron Drive 21037 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner 1 Yes 2 No If Yes, Give Year or Dates. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White "natural" Specify Completed 3 X Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Registered Nurse Medical vears Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other transmets. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည August Meyer Isabel Wunderlich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric C. Marcalus/ Son 156 Colony Crossing, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🗓 Other (Specify) Entombment 4/2/11 Davidsonville, MD Lakemont Cemetery 22. Name and Address of Facility George P. Kalas Funeral Home Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician -mrhysema disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performed? ☐ Yes 2 🕱 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 🗷 No Other: 1 Tes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D 29a. Certifier 🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28/11 46052

State

30. Name and address of person,

9

31. Date filed (Month, Da

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Lee March AM alema Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fahrney Keedy Nursina Home Boonsboro MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (in yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 🗆 M 2 😡 F Days Hours october 28,1941 Director 69 277-36-3845 Ohio Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Washington 1 🗆 Yes 2 😾 No Boonsboro 9 10e. Street and Numbe 10f. Zip Code 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 10g. Citizen of What Country? Funeral 72 hours after death with 8507 Mapleville Rd 21713 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No
If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 shourd the most Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Sales self Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roy Frederick Wolfrum Florence Matilda Hohenberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paige E. D'Allura/Daughter 434 Belview Ave. Hagerstown MD21740 20a. Method of Dieposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Borial 2 Cremation, 3 - Removal from State hation 5 Other (Specify) 03/31/2011 Smithsburg, MD Smithsburg Crematorium 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury the Funeral Director: After this certificate has been signed by the arending physician and releted filled in by the funeral director, page 2 should be detached fir use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has I autopsy 2 No Yes 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) မြ Other. ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, MD Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Norman Maver 201 Î 11:52 March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1244 Magnolia Ct. Hagerstown Washington County Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 1 X M 2 □ F 193-24-4501 79 March Day YT932 **Director** Pennsylvania Usual Residence of Decedent 28a-f show 10a State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 X Yes 2 □ No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1244 Magnolia Ct. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forceş? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 's my injury or other traumatic event, the Me any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Pastor Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Nelson Mayer Mary Marjorie Glass Mayer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy R. Mayer-wife 1244 Magnolia Ct. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 4-3-2011 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner teror Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed engestive that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Day 5 Other (specify) Month Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has death? performe After this certificate I Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending injury neral Director: A filled in by the fi 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a Medical 29a. Certifier Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) M, DD0047 3) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21742 3H-10 13424 722 31. Date filed (Month, Day, Year) egistrar's Signature State APR O 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 28, Day 2011 Year James Merrill Marshall, JR. 9:05РМ м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hartley Hall Nursing Home Pocomoke City Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 M 2 - F Months Days Hours Min. Ju^{(Month,1Day, Yea}(931 Vfrginia 214-28-1299 Director 79 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Me iteal Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Pocomoke City, Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3747 Payne Road 21851 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. White 1 Never Married 2 Married þ 1 Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Printing Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Merrill Marshall, SR. Rhoda B. Merritt 19a. Informant's Name/Relationship (Type, Print)
Lois J. Marshall / spouse 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State Zio Code)
3747 Payne Road, Pocomoke City, MD 21851 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of United to Crossition (Name of United to Crossition) 20c. Location - City or Town, State 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State 4/2/2011 4 Donation 5 Other (Specify) Greenbackville, VA Cemetery 21. Signature of Fune a Service Licensee 107 Vine Street 22. Name and Address of Facility Holloway Funeral Home, P.A. Pocomoke City, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final 1) ÉMENTIA Physician/ LZHEIMER' disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and I for use as the burial-transi that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? certificate 2 No Yes 2 D or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be hours after death uneral Director: A 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

State

1604 MARKET

32. Régistrar's Signature

D 62172

ST

POCOMOKE CITY

29d. Date signed (Month, Day, Year)

21851

3/30/2011

R. SATUAL, MD

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

SHARAD

DHMH 17 Rev 7/2009

Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 Month 11:37 PM Ernest Joseph Mueller March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bowie Health Center Bowie Prince George's 5. Social Security Number 8. Date of Birth (Month, Day, Ye August 17, 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 🖾 M 2 🗆 F Months Days Hours 577-34-6598 98 Washington, DC Director Yrs 1912 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director r 28a-f sl notified Maryland Prince George's Hvattsville 1 Yes 2 X No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 5618 Gallatin Place 20781 IISA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō by 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 No Specify: Specify: White "natural" 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) DC Fire Department Firefighter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H ပ John W. Mueller Mary T. Keifer permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda M. Speakes / Daughter 4304 Holmehurst Way, Bowie, MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Fort Lincoln Cemetery 4/1/2011 4 Donation 5 Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue 22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Dementia Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2 No Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 🛚 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D45217 3/28/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adebowale Isaac Ajayi, 6201 Greenbelt Road, Suite M18, Greenbelt, MD 20740

Registrar

State

Date filed (Month

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2<u>011</u> Physician/ Month 7:30 Рм Bernice Laura Morano 28 March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Villa Rosa Nursing Home Prince George's Mitchellville Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🕱 F 553-34-0614 86 Yrs Director September 6,1924 Shannon Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's College Park Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9728 53rd Avenue 20740 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White "natural", 3 X Widowed 4 □ Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatin Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Andrew Brostowzsky Rozalia Barnatowicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Morano, Jr. / Son 9728 53rd Avenue, College Park, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🛭 Cremation 3 🗀 Removal from State Metropolitan Crematory 3/30/2011 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 CA 23a. Part 1. Enter the diease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ TASTRIC DENOCARCINOMA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit Exam Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical death certificate be attending p as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has performed 2 No 1
Yes Yes a No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft To the Funeral Di completed filled in Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28595 rsneen lam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAUD MD 4209 AKHAM, MI) ASNEEM 2835 31. Date filed (Month, Day, Ye Registrar

Box 68760

P.O.

of Vital

AMEND ITEM 200 TER HARVIAND / Department of Health and Mental Hygiene Certificate of Death For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March DOROTHY MACKIN KAHLER 7:54am 2011 . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Civista Charle Conter -a 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 1 F Days Hours Months JUNE 4, T930 80 MARYLAND Director 215-28-2569 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD CHARLES WALDORF 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a U.S.A. 4140 OLD WASHINGTON ROAD 20602 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3X Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SECURITY CLEARANCE OFFICER U. S. GOV'T. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KATIE MAE HARTMAN WILLIAM KAHLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN HEIDEMANN/DAUGHTER 1212 JEFFERSON LANE WALDORF, MARYLAND 20602 Baltimore, 20a. Method of Disposition Date UNK 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ARLINGTON NAT • CEM • ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service License M006415635 WASHINGTON AVE., LA PLATA, MD 20646 ETY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ umonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Asmator Wull Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as consequence of): Physician/Medical that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year the P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' eral Director: After this certificate I filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Yes 2 Ho Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 10 Natural work? 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Chec ctions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 2011 narlene State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John William Nose March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince Georges 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 🔀 M 2 🗆 F Months Hours Country) Director 232-28-3654 92 Aug. 31 .1918 West Virginia Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Yes 2 No Maryland Prince Georges Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9927 Locust Street 20769 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Completed by 1 Never Married 2 M Married 1 V Yes 2 No If Yes, Give WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) r than " the Mr Elementary/Seconday (0-12) Washington Suburban College (1-4 or 5+) Foreman Sanitary Commission Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Jay C. Nose Mate H. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Nose (Wife) 9927 Locust Street Glenn Dale , MD 20769 item 2 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place) 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 3/30/2011 Beltsville, MD 21. Signal Puperal Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 23a art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between I mediate Cause (Final isease or condition Onset and Death Physician/ Congestive Heart Disease Medical resulting in death) **Examiner** Coronary Artery Disea.
Due to or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Yes ours after death.

eral Director: After this certifica filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a Medical 29a, Certifier Certifying Physician to the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28920 3/29/2011 Singh 7319 A Hanover Parkway Greenbelt, MD 20770 Suringer 31. Date filed (Month, MAR 3 1 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 Irene E. Crichlow Parker 2011 10:53a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1526 Nova Avenue Heights Capitol Prince Georges 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 F Months Hours Min. (Month, Day, Year LaPlata,MD Director 96 Yrs. 579-20-2804 Usual Residence of Decedent or 28a-f shov notified at shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Capitcl Heights 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 1526 Nova Avenue 20743 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🖾 No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: Afro American Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Classified Laborer Naval Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ۴ Ollie Hemsley traumatic Helen Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allwyn F. Crichlow, Jr/Son 1526 Nova Avenue Capitol Heights MD 20743 other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State ☐ Burial 26th Cremation 3 ☐ Removal from State cemetery, crematory or other place) Beltsville, Maryland Chesapeake Crematory 02/24/2011 4 Donation 5 Other (Specify) 21. Sanature Funeral Service bicens 22. Name and Address of Facility John T. Rhines Funeral Home LLC BOO5 12th Street NE Washington DC 20017 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ays nediate Cause (Final Pnysician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or impury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

The the Thornal Director: After this certificate has been signed by the attending physician the property of the physician physi P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 1 ☐ Yes 2 ₺ 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 X No 2 1 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 🗌 Yes 2 区 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 K Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🛚 🖸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 📙 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Hemen, MD

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Greenbelt Road, Lanham MD 20706

D50862

Sherif Hassan MD

FEBRUARY, 23, 2011

State of Maryland / Department of Health and Mental Hygiene 1 State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 12:30 A M Loretta Olga Pinckney 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hvattsville Prince Georges Thomas More Nursing Home 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex **Funeral** 1 □ M 2 🛣 F 2 Month 1 Day, Days Country) Months Min. **Director** 578-56-6638 67 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Prince Georges Mt. Rainier 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Numbe Funeral 20712 United States 3366 Chillum Road Apt. 102 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify 3 Widowed 4 Divorced Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Health Care Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Reginald Creek <u>Julia Mae Johnson</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1225 Stockport Court Mitchellville, MD 20721 Carla Sanders/ Daughter permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 104/01/2011 Brentwood, MD 21. Signature of Fundral Service Livensee 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Hepotic Euceph a long T Ph_sician/ 40515 year 531 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it arry, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Direct of the osin priparationne of ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Other (specify) 2 No Yes ☐ Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? The ombocytopenia 1 ☐ Yes 2 ☐ No this certificate Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မှ completed filled in by the funeral 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: After t (Month, Day, Year) 1 Matural 5 Pending 1 Yes 2 No s after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MARCH Z3 2011 HaaTKSVille MIL veensbury Rd ORE 31. Date filed (Month, Day, Year) State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			For State	State of Maryla					and Me	ental Hy	giene	2011	1 9	L
			Registrar 1. Decedent's Name (First, Middle, Las:	<i>t</i>)		<u>Certificate</u>	of L	Death			Reg. No			
	Physicia			ayne						2. Date of De Menth	eath 25	2 0 °°°	3. Time of De 1 4:15	
	Medic Examin		4a. Facility Name (if not institution, give			4b. City, Town, or Location of Death						County of Dea		
معرد بيه			Southern MD	Hospital		Cli	nto	on				-	George':	s
	Funeral Director		5. Social Security Number 6. Se 1 245-40-9853	x 7. Age (ln yr ☐ M 2 🔀 F 79	rs. last birthda Yrs	Months	Year Days	If Under 2		8. Date of Bir 3 (M3) (Pa		g. Bi	rthplace (State or F	oreign
٥			Usual Residence of Decedent			s.			1	3/30/	1931		14C	_
viand	f sho	ctor	10a. State 10b. County		City, Town o					-			10d. Inside City I	
e W	r 28a notifi	Director	MD Prince 10e. Street and Number	George's	Cli	nton) - I -						1 XYes 2	☐ No
with #	23a c Ist be	eral	4708 Plata S	treet	10f. Zip Code 20735							10g. Citizen of What Country? USA		
land 21215-0036 be filed within 72 hours after death with the Maryland	tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, <u>the Medical Examiner must be notified</u> at	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S.	13. Was Deceder If Yes, specify				14. Race - American Indian,				
36	l", or xamin	d by	1 Never Married 2 Married	1 ☐ Yes 2 ☐xNo If Yes, Give		1 Yes 2				can, etc.)		Black, Whi		
9	atura cal E	Completed	3 🔀 Widowed 4 □ Divorced 15. Decedent's Ed	Year or Dates.	16a. De	ecedent's Usual						ind of Business		
215	e. Med	dmc	(Specify only highest grades) Elementary/Seconday (0-12)		I (G	ive kind of work e. DO NOT use r	done c	during most	t of working	7	100. KI	ma or business	industry	
7	Hygien other th	Be C	12th		Cl	erk Ty	pi					t. of	Navy	
anc	ked o	TO E	17. Father's Name (First, Middle, Last) Lee Grant Mal	lov						First, Middle,		Surname) .liams		
ary Pould	of Health and Mental F fitem 27 is marked of r other traumatic even		19a. Informant's Name/Relationship (Ty)		19b. N	lailing Address (S	Street :	-					in Code)	
2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	n 27 is	3	Althea J.Wilson	/dtr.	- 1	8 Plat							p dddy	
Baltimore, Maryland 21215-0036	t of He If iter or oth		20a. Method of Disposition 1 XBurial 2 Cremation 3		b. Place of Di cemetery,	sposition (Name crematory or oth	of er plac	e)	Da	te	20c. Lo	ocation - City o	Town, State	
Itimo	irtmen irtant: njury		4 Donation 5 Other (Specify	H	armon	y Mem.				2011		dover		
Ba	Department of H Important; If ite any injury or oth		21. Signatur of Funeral Service License	BUXOTTON	110	22. Name and 2294 O							eral Hor	
			23a. Part 1. Enter the disease or comp shock, or heart failure. List only on	lications that caused the d	eath. Do not							ITUOLI	Approximate	
Ph	ysician	0 4	Immediate Cause (Final disease or condition	ATheresi	lerot	ic Ca	1	20 100	ac. la	1	Ha	-	Onset and Dea	
	Medical xaminer		resulting in death)	Due to (or as a cons	equence of):		7			n N			7,	
		Jer	Securationly list conditions if any, leading to immediate	Due to (or as a cons	equence of):	r	ne	ungr	and a				109	
uted	ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	· ·	. ,									
executed			resulting in death) Last	Due to (or as a cons	equence of):								,	
Sate be	has been signed by the attending physic ie 2 should be detached for use as the b	Physician/Medical		d										
Box 68/60 death certificate b	nding use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of prec								23d. Date of de	diven	
Goa th	e atte	sicia	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 F 4 Pregnant at time 9 Unknown		3 Ectopic pre 5 Other (spec		:y			'	Month	Day Yea	r
that the	d by the		9 ☐ Unknowh Part II. Other significant conditions co		resulting in th	te underlying co	uno di	on in Part I		00 8111				
res ∄	signe d be d	d by	The state of the s	to death but not	resulting in th	te dilderlying ca	use giv	en in Faiti.					o the cause of deat Probably 450 Uni	
VITAI KECOFGS, nysician: The law requires	shouli	Completed								24a. Was			itopsy findings ava	
Fe lav	te has age 2	omb								auto perfo	psy ormed?	prior to death?	completion of caus	se of
20 ia	s certificate ha	Be C	25. Was case referred to medical examiner?				26. Pla	ace of Deat	th (Check o	1 \(\text{Yes}\)	2 1540/140) ILITE	s 2× No	7
T VII	this or al dire	၉	1 Yes 2 No	lospital: 1 Impatient 2 28a. Date of injury	ER/Outpa			4 ∐ Nu	rsing Hom	e 5 🗆 Resi	dence 6	Other (Spec	cify)	
n OT	th. : After > fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	inju		lnjury work 1 🗆		- 1	d. Describe l	now injury	occurred		
DIVISION tal or Attendir	er dea ector by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe			_					l Number or Ru	ıral Route Number,	
	urs aft ral Di									City or Tov				
Hosp.	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic: completed filled in by the funeral director, page 2 should be detached for use as the b.	Medical	(Check 2 L Medical Examin	cian: To the best of my knower: On the basis of examina	ition and/or in	vestigation, in my	opinic	n. death occ	curred at th	e time, date a	and place.	and due to the	cause(s) and manne	er stated.
To the	within To the compl	Σ	only one) 3 LI Certifying Nurse 29b. Signature and title of certifier	e Practioner: To the best of		29c I	icense	number			20d Det	a signed (Mont	h Day Vanel	
			m85			1	JES	365			03-	-25-26	olf	
	22		30. Name and address of person who co	. 4 . 4 / -	em 23a) (Typ	e, Print)	W.	46	I FC	mal	Johan	W) 2	27 Cr	
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Michael Herbert Padgett

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	State o	f Marylan	d / Den	artment o	f Health	and Me	ntal Hydi	ene

	1- For State Registrar	C	ertificate of	Death		Reg	g. No.				
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of Death										
	Michael Herbert	Day Year 2011	1436 hrs								
	4a. Facility Name (if not institution	4c. County of Deat	h								
	4640 Strauss Avenue		Charles								
Funeral	5. Social Security Number		. last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. Bi	rthplace (State or			
Director	212–98–9159	1X M 2 F 32	Yrs.	Months Days	Hours Min.	1	Forei	gn			
Director	bec. 25	5, 1978 c	puntryMaryland								
	Usual Residence of Decedent	140+ 0	t. Town as I contin	_				10d. Inside City Limits			
v any	10a. State 10b. County	10C. CI	ty, Town or Location	on							
short and	Maryland Prim	nce George A	ccokeek					1 Yes 2 XNo			
Sa-f	10e. Street and Number			10f. Zip Code	-	10	g. Citizen of What Cou	intry?			
the Marylan a nr 28a-f si tified at one Director	18121 Indian He	U.S.A.									
vith t		12. Was Decedent Ever in	U.S. 13, Was	20607 Decedent of Hisp		cify Yes or No-		rican Indian, Black,			
r death with or items 23 : must be no	1 Never Married 2 M	arried Armed Forces?		es, specify Cuban,	Mexican, Puerto F	Rican, etc.)	White, etc.				
a sille	3 Widowed 4 Div	1 Yes 2 No vorced If Yes, Give Year		Yes 2 X No	specify:		Specify: Wh:	ite			
s aft in S	15 Decedent's Education (See	or Dates: cify only highest grade completed)		's Usual Occupation		ork done	16b. Kind of Business				
OO36 within 72 hour giene. ber than "natu £. Medical Exan	Elementary/Secondary (0-12)			st of working life.				,			
ole ical	12	College (1-4 of 5+)	Labor	o.w			Self Emp	Lovo I			
5-003 iled within Hygiene. I other the Med	12	<u> </u>	Labor		8.Mother's Name (Circt Middle M		LOyeu			
Hygh Hygh	17. Tatilot o Maine (Firet, Miladie			110							
1215-0036 Id be filed within 72 hours at fental Hygiene. sarked other than "natural event, the Medical Examin on Be Completed by					Linda K.			-			
D 21	19a. Informant's Name/Relations						per, City or Town, Stat	e, Zip Code)			
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medical To Be Comple	Darlene Y. Gili				_		4d. 20616				
Heal an	20a. Method of Disposition 1 Burial 2 Cremation		p. Place of Disposi crematory or oth	tion (Name of cemer of Ap)	etery, rill 2 20	Date	20c. Location - City o	r Iown, State			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s nr 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director			rinity M	emorial (Gardens	J11	Waldorf. I	f, Maryland			
y arta e	4 Donation 5 Other S 21. Signature of Eunerah Service	Decity	_					I, Paryland			
Depa Depa	11 - 1/ 1	// _/	668 Wi	ame and Address of Iliams Fi	uneral Ho	ome, P.A	A	20640			
and the little and th	23a Part I Potenthe disease or	complications that caused the dea	th. Do not enter th	// Hawtho	orne Rd such as cardiac or	respiratory arre	1 Head Mo. st. shock, or heart	20640 Approximate Interval			
hysician	failure. List only one cause	on each line. Hyperten	sive Car	diovascu	lar Disea	ase com	plicated	Between Onset and Death			
Examiner	Immediate Cause (Final disease							Deadi			
	or condition resulting in death)	Due to (or as a consequence	e of):								
	Sequentially list conditions,	b									
	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	e Or).								
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Sox 687 leath certifi e attending for use as I	past 12 months?	4 Pregnant at time of	de ette	ner (Specify)							
D. Box 68 t the death certif by the attending ached for use as	1 Yes 2 No 9 Un	known 9 Unknown		_							
Tithe d	Part II. Other significant condi	tions contributing to death but no	t resulting in the u	nderlying cause gi	ven in Part I.	23e. Did tot	pacco use contribute to	the cause of death?			
Records, P.O. The law requires that the ficate has been signed by it, page 2 should be detach.	Morbid Obes:	ity				1 Yes	2 No 3 Pro	obably 4 🗹 Unknown			
quire en si, ald b						24a. Was a	n 24b. Were a	utopsy findings available			
ords, w requir as been s s should t						autops perfori		completion of cause of			
Phe la						1 Yes 2					
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safer death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P.					of Death (Check o	nly one)	· · · · · · · · · · · · · · · · · · ·				
Vita	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other Nursing	Home 5 F	Residence 6 🗹 Oth	er: Scene			
n of Vi	27. Manner of Death	28a. Date of Injury	28b. Time of Ir	njury 28c. Injury	y at Work?	28d. Describe h	ow injury occurred				
io e fur	1 X Natural 5 Pen	(Month, Day, Year) ding		1 Y	es 2 No						
SiO Atter deal by th	2 Accident Inve	estigation 28e. Place of Injury - A	t home farm stree	t factory office by	uilding etc	28f Location (S	treet and Number or F	tural Route Number, City			
Division o spital or Attending tours after death neral Director: After filled in by the fune Certification:	3 Suicide 6 Cou	ld not be	riono, idin, odoc	it, 100t01y, 011100 20	, individual services	or Town, St					
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n 24 n 24 letelyletely	(Check only 1 Certifying P	hysician: To the best of my knowl aminer: On the basis of examination									
Division of Vital Records, P.O. Box 68760, Ta the Hopital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transi Medical Certification: To Be Completed by Physician/Medical Ex	one) 2 Medical Exa	and manner stated.	3 3 gat								
2	29b. Signature and title of certifi	er		29c. License			29d. Date signed (M				
	Addan K	rayell al		O.C.N	л.E.		March 28, 2011				
NOI	30. Name and address of person	n who completed cause of death (It					<u> </u>				
NOI	Melissa Brassell, MD	Assistant Medical Exar	niner 111 P	enn Street, Ba	altimore, MD	21201					
State	31. Date filed (Month, Day, Year)		ature								
Registra	MAR 31	2011 Coners	A. Spark	The state of the s							
	COM	7	ORIGINAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March Physician/ Jeanette Rose 9:55 P M 23 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carriage Hill Nursing and Rehab Center Montgomery Bethesda If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛣 (Month, Day, Y Days Hours Virginia 88 **Director** 224-20-6453 January Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland of Mental Hygene.
marked other than "natural", or items 23a or 28a-f show maric event, the Medical Examiner must be notified at ms 23a or 28a-f sho must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🂢 No Virginia Arlington Arlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22204 United States 1201 S. Courthouse Rd. Apt. 603 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev Mollie Bress Arthur Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hannah Leah Aurbach / Sister 5630 Wisconsin Avenue Apt. 206 Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March 2011 Alexandria, Virginia Agudas Achim Cemetery Signature of Funeral Service Mcensee 22. Name and Address of Facility 5755 Castlewellan Drive polin Alexandria, VA 22315 Jefferson Funeral Chapel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia, Aspiration disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Aortic Stenosis, Severe Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 5 Other (specify) 2 💢 No as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page death? 1 Tes Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 🔀 No Other: 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 2 Accident
3 Spic X Natural 5 Pending 24 hours after death.

Funeral Director: After the further of the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Frantioner: To the best of my knowledge, death 29b. Signature and tit of certifie 29d. Date signed (Month. Dav. Year) 29c. License number 28 201 D35579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bethesda, Maryland 20814 Susan J. Miller, M.D. 8218 Wisconsin Ave. #305 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Mary Edith Baker Raabe March 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** '. Age (In yrs. last birthday) (Month, Day, Year) Days Hours 1 🗆 M 2 🛛 F Country) Melrose 216-30-4088 78 Yrs. Director June Usual Residence of Decedent or items 23a or 28a-f shov miner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No University Park Maryland Prince George's 10e. Street and Number 10g. Citizen of What Country? Funeral 20782 4112 Woodberry Street USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White "natural", Specify: 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mea any injury or other traumatic event, the Mea gines. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Whiteford Lee Baker Mary Alma Jowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles T. Raabe / Husband 4112 Woodberry Street, University Park, MD 20782 20b. Place of Disposition (Name of cemetery, gematory or other place) Angelus United Methodist Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State 4/2/2011 Jefferson, South Carolina 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. PAG Regers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. Fracture Right Herm rous disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner # H00559 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last physician and the burial-trans Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 88 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy malletu. performed? Yes 2 N Drabeter 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical completed filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? 1 X Yes Other: 2 🗌 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at 27. Manner of Death Certificate: 28a. Ďate of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Fell 1 Natural 2 Accident 5 Pending 4 cince MARCE 23 ZON UNENO hours after death. Ineral Director; A 1 L Yes 2 No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4/12 Wood Derry University Penk May Car determined To the Hospital o within 24 hours af To the Funeral Di ome Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title o 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 5632 (China polis Rd. Suito 13, Bladensburg, MD. 20710 ; la MD 31. Date filed Month, Day State 30 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last), 2. Date of Death 3. Time of Death Physician 00 201 MARCH /Medical 4a. Facility Name (If not institution, give street and pumber) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomer alley lursing How Utomac 0000111 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, If Under 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 M 2 F Months Oct. 98 1912 NJ Director 139-10-5842 14, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examinar must be multified at 1 Yes 2 No **Funeral Director** MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8505 Springvale Road, #225 20910 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White If Yes, Give Year or Dates: Specify. Completed by 3 2 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Fedosh Sr. Unknown Wanca ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paul Boucher/Grandson 3854 Braveheart Drive, Frederick, MD 21704 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 3/29/11 Monroe Township, NJ St. James Cemetery 4 ☐ Donation / 5 ☐ Othler (Specify) 21. Signature of Funeta Service Lic 22. Name and Address of Facility 500 University Bi Bivd. W., Silver spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy 1 ☐Yes 2☐No 1 ☐ Yes 2. No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day, Year) After the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: ours after death. neral Director: Af filled in by the fur within 24 hours a Completely

> State Registrar

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature

32. Registrar's Signature

2 Medical Examiner: On the basis of examination a and manner stated.

29c. License number

mole

dor investigation, in my opinion, death occurred at the time date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [9] For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 25 10:00 a^M Eileen Marie March 2011 Spak Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 413 Dennis Avenue Silver Spring Montgomery 8. Date of Birth
Jan. 31, 1925 Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 🗆 M 2 🖾 F **Director** 269-20-7060 86 OH Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 413 Dennis Avenue 20901 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 K No Black, White, etc. ò 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: White "natural", Specify: 3 Midowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Cardiovascular Cath Lab Tech Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked of permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic ew Hugh Kellackey Clara Citkowsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Lee Spak/Daughter Bethesda, MD 20814 7814 Marion Lane, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 12 Burial 2 Cremation 3 Removal from State March 2011 4 ☐ Donation 5 ☐ Other (Specify) Holy Ghost Cemetery Newburg, MD . Signature_of Funeral Service Licensee P22. Name and Address of Facility Francis J. Collins Funeral 500 University Blvd. W., S Home Inc. 1ver Spring MO150 ,MD 20901 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ Chronic Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or). Due to (or as a consequence of): resulting in death) Last as the burialattending physician Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown for 5 Other (specify) signed by the a P.O. Part II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Hypertension, Gastroesophageal Reflux, Anxiety Division of Vital Records, 1 Tes 2 No 3 Probably 4 M Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 🛣 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖺 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7 D53199 March 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue, Takoma Park, MD 20912 Natasha Lamming-Lee, MD 31. Date filed (Month, Day, Year) State MAR 29 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2011 | 1921 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:20 P M March 2011 Shneyder Anna Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Montgomery Rockville Hebrew Home of Greater Washington If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) Ukriane (Month, Day, Year) 03/08/1927 1 □ M 2 🕅 F Months Days Hours Director 493-84-6331 Usual Residence of Decedent Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 □ No MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10250 West Lake Drive 20817 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 Never Married 2 Married Raltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pharmacy 4 Pharmacist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ " Unknown Motel Katzevman Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Zoya Brodsky/Daughter</u> Aqueduct Rd. Potomac MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 🛛 Cremation 3 🖳 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/24/2011 Falls Church, VA National Crematory 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc.
1091 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Licensee <u>Kurt Blake</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition colon ancer Metastatic Pnysician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** epoessio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transil Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA ၉ 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M Investigation 6 Could not be Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Priystrain. Of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D69568 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20852 Rockville 6/21 Montose Rd mo A Chipkamara, MD 31. Date filed (Month, Day, Year) **MAR 29 2011** 37. Registrar's Signature State Registrar

Please Type or Brint in Black Indelible երկ Քութսբ / All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) n4 Month 2:35 A M Physician/ 20[°]f°1 M. Smith Doris Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Williamsport Nursing Home Williamsport Washington g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Da Min. Days Day, 1 M 2 XF Baltimore, MD 202-20-1955 1926 Director 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1 X Yes 2 □ No Williamsport Washington MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 154 Artizan St. 21795 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?, 1 Yes 2 No If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 XWidowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) retail store Elementary/Seconday (0-12) clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emma Itter 2 Irvin R. Martz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21043 Ellicott, MD 7716 Sandstone Ct. Darrell L. Smith/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Waynesboro, PA April 6, 2011 Burns Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 21. Signature of F ral Service/Lic.or ee Waynesboro, PA Broad St. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any leading to immedia cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Dav in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the s g Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 3 Probably 4 Unknown 1 Yes Completed been Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 2/10 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 2011 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registra 's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Dorothy Sederbaum 5:20 Pм 27 2011 March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Prince George's 5. Social Security Number 8. Date of Birth
(Month, Day, Yea
March 19, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Davs Min. Hours Country 413-05-8954 90 Director 1921 Knoxville, Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Prince George's Hyattsville 1 Yes 2 No 10g. Citizen of What Country? Funeral 7603 25th Avenue 20783 USA 1 and 2 should be filed within 72 hours after death w f Health and Mental Hygiene. Item 27 is marked other than "natural", or items: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. \$ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hannah Cash John W. Key 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen J. Pardoe / Daughter 8090 Nursery Road, Lusby, MD 20657 or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 4/1/2011 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22, Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Pnysician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Disk to for self-europeadies exphysician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 monthe?
1 ☐ Yes 2 ☐ No Month Day Year the detached P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be det þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 - No ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27, Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1-Natural 5 Pending work? 1 Tes 2 No Accident Investigation within 24 hours after death To the Funeral Director: / completed filled in by the 1 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DO064024 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue LACKETCHININH, M.D. Takoma Park, MD 20912 31. Date filed (Month, Day, Year) State 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 25, Day 2011 5:52 р м Moses Sylva Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Hospice- Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date of bit... (Month, Day, Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Country)
Gambia Hours Min 1 XM 2 **Director** 1988Sept. None Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be Funeral 20902 Gambia 11516 Clairmont View Terrace within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 🗷 No Black White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry within I Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ Page 1 and 2 should be f tment of Health and Menta tant: If item 27 is marked jury or other traumatic en Henrietta Benka-Davis Sang Marie Sylva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henrietta Sylva/Mother 11516 Clairmont View Terrace, Silver Spring, MD 20902 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Potent Page 1. Department of I Important: If its any injury or ot once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State April 2011 Banjul Cemetery 4 Donation 5 Other (Specify) Banjul, Gambia 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Signature of Funeral Service Licensee Home Inc. ilver Spring,MD 20901 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Metastatic Squamous Cell Cancer disease or condition / Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be P.O. Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Month Year signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it completed filled in by the funeral director, page 2 No 1 🗌 Yes Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending Yes 2 🗆 No Acciden
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 _ 3 _ (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number D60634 March 25, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Drive, Rockville, MD 20850 Bindu Joseph, MD 31. Date filed (Month, Day, Year 32. Registrar's Signature State MAR 3 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Month М 27 45 AM March Sanders Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery 9. Birthplace (State or Foreign Country) Poland Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days 1 🛛 M 2 🗆 F Months Hours Month, Day, Year, /15/1917 Director 114-26-0714 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Rockville Montgomery 14 Yes 2 No items 23a or 28a-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6111 Montrose Road #221 20852 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 💢 No Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", White Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dry Cleaning Tailor Ве 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David Sanders Sheine Goldberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 11305 Royal Manor Way Gaithersburg, MD 20878 Fred Sanders - son 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Garden of Remembrance
Memorial Park 4 Donation 5 Other (Specify) 03/29/2011 Clarksburg, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20852 M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 2 disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine for use as the burial-true law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by lon ances of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has , page 2 To the Hospital or Attending Physician: The 1 Yes 2 No Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No director, 26. Place of Death (Check only one) Be Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this within 24 hours at er death.

To the Funeral D rector: After this completed filled in by the fureral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury Natural 5 Pending Division 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4

Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0121 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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tors sower

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3 4,31 AM Medical 4a. Facility Name (if not institution, give street and numb **Examiner** 4b. City, Town, or Location of Death 4c. County of Death mor Social Security Number If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 06-20-1929 1 2 M 2 🗆 F Hours Min Director 218-24-6184 81 Pa 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Md. 1 Yes 2. No Talbot Trappe 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 29053 Sanderstown Road 21673 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify and Mental Hygiene. is marked other than "natural", 3 X Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Connelly Containers <u>Box Cutter</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of
any injury or other traumatic eve Benjamin Green Alice V. Mills Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwen Davis Daughter 1002 Tilghman St., Chester, Pa. 19013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) P<u>aradise Cem</u>. 04-01-11 Trappe, Maryland 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signature Aneral Service L Dover Street, Easton, Md. 21601 Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ mondi Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a c sequence of): Hospital or Attending Physician; The law requires that the death certificate be executed ng physician and as the burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for Month ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 🗹 Unknown 1 Yes 2 No 3 Probably Completed page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 death? certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. e Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate; 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bu **477** 31. Date filed (MMA) Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4.30 P M sasseraron 2011 Medical 4c County of Death
Baltmive sility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner alousville torest Haven VUUS ing If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)

CΔ **Funeral** Hours 1 M 2XX \$\frac{1}{2} \frac{1}{2} \frac 217-58-0412 59 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State should be filed within 72 hours after death with the Maryland Director Catonsville 1 ☐ Yes ※※ No Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 Funeral 701 Edmondson Ave. USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2XXNo Specify: "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Property Manager Vice President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Vena Bauer Wilbur Sasser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shawn Scott Son Annapolis, MD 21401 Glen Ave. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial XX Cremation 3 Removal from State Atlantic Crematory 3/21/2011 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Incensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final NEUMONIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner WEDICAL EXAM Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed NPPROVED BY Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PARAPLECIA 1 Yes 2 No 3 Probably 4 Unknown BLADDER 24b. Were autopsy findings available prior to completion of cause of death? EUROGENIC 24a. Was an has autopsy performed 2 No DIFFICILE 1 Yes 2 🖵 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examinér? Hospital: Other: 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ Yes Nursing Home 5 - Residence 6 - Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of injury 1-10 -2006 UNKNOWN 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes Natural 5 Pending 2 No 2 Accident -all Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 496 R. Ha DRIVE 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined MD Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D28595 mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAKHANI, BARD MA 2120 SmiTH 2835 ASNEDM . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 23. Day 2011 Wilber Daniel Smith 9:20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton 9. Birthplace (State or Foreign Country) Florida Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In vrs. last birthday) **Funeral** 1**X** X M 2 □ F Months Hours 0772971924 86 Director 264-58-5206 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 🛣 No Marvland Anne Arundel Harwood 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4776M Carmody Court 20776 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. KIX Xes 2 □ No If Yes, Give Year or Dates.WW II Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Accounts Receivable Giant Food year Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Julia Daniel Smith Esther UNKNOWN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Mary L. Smith / Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Carmody Court Harwood. Maryland 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Maryland Vet. Cem. 3/29/11 Crownsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Thotal Salvice Livensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 Ectopic pregna5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FAILURE, DIABETES MELLITUS Records, 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION DYSUPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Funeral Director: After the Hospital or Attending thin 24 hours after death. 5 Pending 1 Natural 2 Accident 1 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D52960 -23-2011 MUSA MOMOH MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20769. 12150 ANNA POUS RD # 205 MUSA MOMOHMD 31. Date filed (Month, Day, Year) State MAR 2 Registrar

State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month MARCH 2011 JANE S. SCHLEGEL 07:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death HARFORD HART HERITAGE ASSISTED LIVING FOREST HILL . Social Security Number 7. Age (*In yr*s. **89** If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 176-18-6846 1 □ M 2 🕱 F Months Days Hours Director PENNSYLVANIA Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND CECIL NORTH EAST 1XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 120 EAST WALNUT STREET 21901 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) BOOKKEEPER SECRETARY LUMBER COMPANY Be Department of Health and Mental Health and Mental Health and Mental Health and Important. If item 27 is marked off any injury or office. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HOWARD SEIPT JENNIE ORR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANE SCHLEGEL / DAUGHTER 3305 DEER RUN ROAD, STREET, MARYLAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State APRIL 3 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MAYERDALE CREMATORY 2011 NEWARK, DELAWARE 21. Signature of 5 18 rvice Lensee 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CAR Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign 1 be 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec completed filled in by the funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation Could not be after deatl Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 39889 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHRIL BUL DON MA SPARUS CREA MAC 665 31. Date filed (Month, Day, NAR 31 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11-02386 Jason Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jason Smith		Si - For State Registrar	tate of Maryla		rtment of tificate of		id Menta	Re	2011 eg. No.	1931
Physiciar Medical Examin	n/	1. Decedent's Name (First, Midd Jason	dle,Last) Adam	Sr	mith			2. Date of Deat Month March 28,	Day Year	3. Time of Death 0710 hrs
		4a. Facility Name (if not institution 624 North Main Stree	on, give street and nu			4b. City, Town, o			4c. County of Deat Washington	h
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la		If Under 1 Year		Min.	th(MM/DD/YYYY) 9. Bi	ign
Director	-	212-04-2586 Usual Residence of Decedent	1XM 2F	36	Yrs			11/27/	/1974	ountry)Maryland
e eny	- 1	10a. State 10b. County		10c. City,	Town or Locati					10d. Inside City Limits 1 X Yes 2 No
Marylanc 28a-f sh	Director	Maryland W 10e. Street and Number	ashington	<u></u>	<u> </u>	onsboro 10f. Zip Code		1	0g. Citizen of What Cou	
vith the 3 s 23a or	ᇹ	624 North Main		cedent Ever in U.	S. 13. Wa	L	713 ispanic Origin	? (Specify Yes or No		· A · rican Indian, Black,
	Fune	1 X Never Married 2 N	Married Armed F 1 Yes ivorced If Yes, Give Yes	forces?	If Y	es, specify Cuba		uerto Rican, etc.)	White, etc. Specify:	White
hours aft natural' Examina	ed bo	15. Decedent's Education (Spe	or Dates: ecify only highest gra	de completed)		t's Usual Occupa ost of working life			16b. Kind of Business	/Industry
036 ithin 72 ane.	Completed	Elementary/Secondary (0-12)		1-4 or 5+)		Plur	mber		Plumbing	/Heating
215-0 e filed w lal Hygie ked othe nt, the h	ပ္သ ရွ	17. Father's Name (First, Middle Chester David						Name (First, Middle, I La Juanita		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other transmantic event, the Medical		19a. Informant's Name/Relation							mber, City or Town, Statensboro Ma:	ryland 21713
re, M 1 and 2 F Health f item 2	ŀ	Gloria Deener, 20a. Method of Disposition 1 Burial 2 X Crematio				ition (Name of ce		Date	20c. Location - City o	
timo t. Pages rtment of	-	4 Donation 5 Other S 21. cignatur of Funeral Service	Specify:			Cremat	ory (04/01/2011 Bast-Stau	Frederic	k, Maryland
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outed nd rransit	Exa	events resulting in death) Last	Due to (or as	a consequence of	n. 					
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D. Bo t the deat by the at ached for		1 Yes 2 No 9 Ur Part II. Other significant cond	nknown 9 Unkr	to death but not re	esulting in the u	underlying cause	given in Part	I. 23e. Did to	obacco use contribute to	o the cause of death?
S, P.(wires than n signed Id be det	ed by				_			1 Yes	s 2 No 3 Pro	obably 4 Unknown autopsy findings available
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of Vit	유	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2	ER/Outpatient		ury at Work?		how injury occurred	er. Scene
Sion Attendii r death. cctor: A	catio	2 Accident Inv	estigation Mar 28	th, Day,Year) D: 5, 2011 ice of Injury - At he	FOUND: 0630 hrs		Yes 2 V N	10		Rural Route Number, City
DIVI	Certification:	4 Homicide det	termined (Specify	Residence	1			or Town, 8 624 North Ma	State) ain Street , Boonsbor	o, MD
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying I Certifying I Medical Ex	Physician: To the be caminer: On the basis and manner	of examination a	ge, death occu ind/or investiga	rred at the time, of tion, in my opinio	date and place on, death occu	e, and due to the caus arred at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)
1	Me	29b. Signature and title of certif		A			onse number		29d. Date signed (M March 31, 2011	
	}	30. Name and address of person	· ·				-		1	
5H-4	ate	Zabiullah Ali, M.D. 31. Date filed (Month, Pay Year	Assistant Medi	cal Examiner		n Street, Ba	Iltimore, MI	D 21201		
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	Funeral		5. Social Security N			7. Age (In yrs. Ia		ay) If Und	er 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bir	th		Pirthalago (State or Foreign	
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336	s after al", or Exami	d by	1 ☐ Never Marr 3 ᡚ Widowed		d 1 X Yes If Yes, Give Year or Da	2 □ No WW	II		2 _ No			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Specific	white	
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/ <i>2011</i> Maryland	and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Na Frank S			-Son								or Town, State,	Zip Code) MD 21842	
30/ ore, I	f Healt f Healt item 2 other		20a. Method of Disp	position		20b. P	lace of D	sposition (Na	ame of			ate			or Town, State	
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Box 6	e deatl the att hed fo	ysici	in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	4 ☐ Pregr 9 ☐ Unkn	nant at time of c	leath	5 Other (s		,				Month	Day Year	
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00 Z.Z	tal or / rs after al Dire ed in b	Ce	4 Homicide	determin	ed buildir	ng, etc. (Specify)		,,			City or Tov			rara roate varisti,	
$\tilde{\mathcal{N}}$	Hos 24 hc Fun	Medical	(Check 2	Medical Exa	hysician: To the ba	is of examination	and/or in	vestigation, in	n my opinio	n, death o	ccurred at t	the time, date a	and plac	e, and due to the	ne cause(s) and manner stated.	
1	To the within 2 To the comple	Ž	only one) 3 29b. Signature and	Certifying N	urse Practioner:	To the best of my	/ knowled	ge, death occ	surred at the	e time, date	e and place	and due to the	ne cause	(s) and manner	as stated.	
			CA. V	ang	mord	MD			D5	430	7		Ma	urch 3	0,2011	
4	3 A 3+1		30. Name and addre	ess of person w	o completed caus	e of death (Item	23a) (Typ	pe, Print)	Henl	thun	u Dr	NO RO	diu	MD:	inth, Day, Year) O, 2011 U8[[
i	Stat		31. Date filed (Mont	th, Day, Year)	0014 32.76	egistrar's Signat	ture	1/33	1100	- 17 104	J	.4 20	* ****	11100	~ 0/1	
	Registra	ir		MAR 30	ZUIT	were,	B. X	parke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 4, Thelma Helen Smith 2011 Μ 2328 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Western Maryland Regional Medical Center Cumberland **Allegheny** Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days April 26, 1 🗆 M 2 🔀 214-28-2466 79 Maryland Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 Funeral United States of America 714 Maxwell Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 3 XWidowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Merhl Edgar Morgan Mary Elizabeth Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patti Caudill / Daughter 16418 Old Emmitsburg Road, Apartment 1, Emmitsburg, MD 21727 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Gardens April 9, 2011 Frederick, Maryland 22. Name and Address of Facility

Keeney & Basford P.A. Funeral Home
106 Fast Church Street, Frederick, Maryland 21701 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ releul disease or condition yoco Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been executed to the property of ending physician and use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Yes ∠ ₹ 9 ☐ Unknown detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should Were autopsy findings available prior to completion of cause of 24a. Was an 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ျပ 1 Tes 2 - No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Paul P. Traver 10:10 pM March 27, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Chevy Chase Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months 1 X) M 2 □ F Director 579-36-2327 80 March 27.1931 Washington. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notifled at 10d. Inside City Limits Director 1 □Yes 2 X No Maryland Prince George's Huattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7012 Partridge Place 20782 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important if flem 27 is marked other than "natural", or items 23 any injury or other traumatic. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) University Professor Education 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Traver ပ Mary Bennett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Kathryn Traver - Spouse 7012 Partridge Place, Hyattsville, Maryland 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Dorfation 5 Other (Specify) 03/31/2011 Silver Spring, MD Gate of Heaven Cem. e of Fluneral Service Licens 21. Signatu 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dvanud **Physician** parkinsons /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Das to for as a consequence of: Examiner the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical the as If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy perform certificate 2DNo To the Hospital or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After to appletely filled in by the funera Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00054566

State Registrar

MAR 29 2011

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State RegistramEND#10eperFH,4/5/11;BWW,McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day THOMAS WILLIAM MARCH 2011 10:15 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Medical Prince Georges Center Cheverly Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Date of Billion (Month, Day, 1 XM 2 D F Min Months Davs Hours 578-20-9601 Washington, DC Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Washington, DC 5 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a or Examiner must be S.E. Funeral USA 5043 Benning Road 20019 12. Was Decedent Ever in U.S. Armed Forces? 1 Ayes 2 No If Yes, Give Year or Dates. WW─II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Black the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Launderer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ Charles Henry Clara Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 5620 Foete Street 20NE 9 Darlene Thomas-Davis/Daugther Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State 3/28/11 Resurrection Cem. Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street NW, Washington, DC 20011 M00969 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ COMPLICATIONS OF BLADDER CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ᅙ HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed DIABETES MELLITUS TYPE II 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital Other: 2 X No 1 Tes 읻 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 1 X Natural injury 5 Pending hours after death.

neral Director: Aft
d filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) So we las MD# D0058627 MARCH 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SONIKA PANDEY, M.D., VAMC 50 IRVING STREET NW, WASHINGTON, DC 20422/688 31. Date filed (Month, Day, Year) State MAR 3 0 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month 59 MARCH 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HOS TIMORE Social Security Number If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Hours Min 82 0/19/11/89/19929 Kobentyapan 212-40-5710 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 No Anne Arundel Severn 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21144 1453 Maryland Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 X No Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 x Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 02 Assembler 4 8 1 General Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Miyoshi Hara Yoshiye UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 453 Maryland Ave Severn, MD 21144 Sherry Lee White Daughter Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) tlantic Crematory 03/26/2011 Glen Burnie, MD 21. Signature of Fureral Service License 22. Name and Address of Facility Hardesty Funeral Home P.A. Sal Part 1. Ent -/ If e disease, r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) signed by the attending physician and de detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 month Month Day Year 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Ves 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 2 🐷 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 140 Other: 1 Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗆 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 001 HANOVER STREET, BALTIMORE HASSAN MASRI 31. Date filed (Mo Registrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienéfor State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Raymond Z. Taylor March 23, 2011 11:40 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₩ M 2 □ F Months Days Hours March Day, Y 1939 Idano" 72 **Director** 518 42 5382 Usual Residence of Deceder 28a-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Brandywine Prince George's Maryland 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? United States items 23a Funeral 20613 14246 Brandywine Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

X Yes 2 \(\text{No 1958-} \) Black. White, etc. 1 Never Married 2 Married þ "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2, No Specify: Specify: White Completed 3 Widowed 4 Divorced 1960 the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic execution. Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Electrician 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Basil D. Taylor Cleo (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Taylor (wife) 14246 Brandywine Road, Brandywine, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Waldorf, MD Trinity Memorial Gardens 3/29/2011 4 ☐ Donation 5 ☐ Other (Specify) Funcial Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Clinton, MD 20735 /art/ . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Imm viate Cause (Final Onset and Death Physician/ MUCLE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami and -transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 Name and address of person who completed cause of death (Item 23a) (Type, 284t 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Garks Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 03/14/5011. 11:36 PM <u>Mozella Ida Lee Taylor</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince Georges 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 - M 2 XF Hours Min. 1270971917 Director 93 033-01-5357 Usual Residence of Decedent 28a-f show 10b. County ral", or items 23a or 28a-f shore Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5405 Tinkers Creek Pl. 20735 AZU 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 75 Chef Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည James Henry Richardson Minnie Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is n 5405 Tinkers Creek pl., Clinton, MD 20735 inda Crawford / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🐹 Cremation 3 🗆 Removal from State Chesapeake Crematory 03 29/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Under 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car liac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on the Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying
Cause (Disease or linjury physician and the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 D been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 XN 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes ဂ္ 1 ☐ Inpatient 2 ♥ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work?
1 \(\subseteq \text{Yes} \) within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number person who completed cause of death (Item 23a) (Type, Print) State Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:35 DM March 33: 2011 /Medical NELLIE KATE TYLER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manakin Manai comerset 8. Date of Birth (Month, Day, Year)
Oct. 7, 1916 9. Birthplace (State or Foreign Country)
Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F Yrs. Director 94 224-28-6319 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Director 1 XYes 2 No Crisfield Maryland Somerset 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or a may injury or other traumatic event, Ite Medical Examinar must be an any injury or other traumatic event, Ite Medical Examinar must be an any injury or other traumatic event, Ite Medical Examinar must be an any injury or other traumatic event, ite Medical Examinar must be an any injury or other traumatic event. 21817 USA 13 Wynfall Avenue Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXVo Specify 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sewing Factory Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Millie Blackwell John William Wolfe 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Wynfall Avenue - Crisfield, MD 21817 Shirley Sterling (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Sunnyridge Mem. Park Mar.25,2011 Crisfield, MD 21. Signature of Funeral Service Ucensee

22. Name and Address of Facility BRADSHAW &

Mary Beth Bradshaw-Pruitt 306 W. Main St. - Crisf

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HME 306 W. Main St. - Crisfield, MD 21817 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 □ Yes 2. No 1 🗌 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 27. Manner of Death 1 Natural To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/23 /11 D47094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 44215130 Mg 5. DIVISION 31. Date filed (Month, Day, Year) 32. Redistrar's Signature MAR 28 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11942 State of Maryland / Department of Health and Mental Hygiene? 1 - For State of Maryland / Department of Health Registrar Amend # 8perfuneral home 4/5/2011 Codon Fb

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 30°, 201911 6:30 a M Mary Alice Vernon Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death 12433 Neale Sound Drive Cobb Island Charles 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth _{Year)} 1921 **2011** 9. Birthplace (State or Foreign **Funeral** (Month, Day Ye 1 □ M 2 😿 F Hours Min. Maryland 215-36-5610 89 Director Usual Residence of Decedent ifiled within 72 hours are trained. It hygiene. It hygiene. It had other than "ratural", or items 23a or 28a-f show the went, the Medical Examiner must be notified at 10b. County rector 10a. State 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Charles Cobb Island 吉 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12433 Neale Sound Drive 20625 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. rmed Forces? Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Bookeeper Retail Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked off any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Virginia Myrtle Duffy Joseph Clagget Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6180 Indian Head Highway, Indian Head, Md. 20640 Dorothy Crown Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Episcopal Church cemetery, crematory or other place) Waldorf, Maryland Paul 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service Licer M00668 4270 Hawthorne Rd., Indian Head, Md 20640 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Templous 3 Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine the burial-transit Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 performed Yes 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical director, 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Sc Dimcheser 1 ☐ Yes 2 🗷 No ြု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 □ only one d title of certifier 29b. Signat 29d. Date signed (Month, Day, Year) License number eath (Item 23a) (Type, Print) rson who completed cause of 117rc 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **MAR 31** Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08 Day 11:45aM Dorothy Hoover Whitmarsh March 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Potomac Byron House Montgomery 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Illinois 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 1 M 2 X F Days Min. 98 8970971912 **Director** 404-16-1270 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9210 Kentsdale Lane, #215 20854 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Yes 2 X No Yes, Give \$ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed 3 X Widowed 4 Divorced Specify: Caucasian Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene, 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Asst. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Diver Louisa Sumner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Charles B. Hoover - Son 10518 Sideburn Court, Fairfax, VA 22032 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Arlington Natl. Cem. | 04/13/2011 | Arlington. Virginia 21. Signature of Funeral Service L 22. Name and Address of Facility Everly Funeral Home M01621 10565 Main Street, Fairfax, Virginia 22-3odo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Thrombophilia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner <u>Myeloproliferative Disease</u> Sequentially list conditions. Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) springle transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Records, P.O. Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 \(\subseteq \) Yes 2 \(\bar{X} \) No Month Year Day Pregnant at time of death should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? certificate 1 Yes 2 No Yes Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specific) 2 **X** No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Curtifying Nurse Fractioner To the best of my knowledge, det the fact 29b. Signature and ≰itle of ce 29d. Date signed (Month, Day, Year) 10 D26571 March 09, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 10605 Concord Street, Kensington, Maryland 20895 Irving Mizus, 31. Date filed (Month, Day, Year) MAR 29 2011 Registrar

WHITMARST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 966 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 24 ^{Day} 2011 Physician/ 8:01 A M WARREN ROBIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S PATUXENT RIVER HEALYH & REHAB. LAUREL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, 43 Yrs. **Funeral** Days Hours Min MARCH 24 1968 NEW JERSEY 577-94-2427 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a, State Director 1 X Yes 2 No MD PRINCE GEORGE'S LAUREL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 13001 MISTLETOE SPRING 20708 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. ģ 1 X Never Married 2 Married BLACK 1 ☐ Yes 2 No Specify: If Yes. Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) NONE 12TH NONE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 GLORIA J. SELDON ROBERT L. WARREN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13001 MISTLETOE SPRING LAUREL, MARYLAND 20708 19a. Informant's Name/Relationship (Type, Print) DAVID WARREN/BROTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State WALDORF, MARYLAND HERITAGE CEMETERY 3/29/11 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death bond enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final STAGE Physician/ incourn disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After Law 1997. use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 X No 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number Rita Dhawan, MD MARCH 28, 2011 D62534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITA DHAWAN M.D. 9055 CHEVROLET DRIVE #103 ELLICOTT CITY, MARYLAND 31. Date filed (Month, Day State MAR 3 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:15 A M VERNA LEE WOOD MARCH 26 2011 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT **EASTON** 29515 HAWKES HILL ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Hours 1 🗆 M 2 🗶 F Months 1070771926 MARYLAND 84 **Director** 215-20-1483 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No **EASTON** MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 29515 HAWKES HILL ROAD 21601 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE If Yes, Give 3 Widowed 4 Divorced Year or Dates event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTS RECEIVABLE CLERK TRUCKING permit. Page 1 and 2 should be filed with Department of Health and Mental Hyglen Important: If item 27 is marked other than injury or other traumatic event, the 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည ETHEL MARSHALL WALTER P. SHAFFER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) PAULA H. KARR / DAUGHTER 28214 WOODLAND COURT, EASTON, MD 21601 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State WOODLAWN MEMORIAL
PARK 04/02/2011 EASTON, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 JOHN MERCERON R 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ on sestive Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Veal Day 5 Other (specify) Pregnant at time of death n signed by the a ld be detached f a | IInknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? death? 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \sum Nursing Home 5 \hbbecktop Residence 6 \sum Other (Specify) 1 Yes 2 Mo <u>م</u>| 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MA ahjo 1115/132

∇ State Registrar 598 CYNWOOD DR., SUITE 104, EASTON, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

JORGE H. ABREGO, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician/ 9:53 AM Williams 2011 Elenora Minnie March Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Talbot Easton Genesis HealthCare -The Pines Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Funeral (Month, Day, Year) 06-17-1922 1 ☐ M 2 🕱 F Months Days Hours Min Maryland **Director** 213-18-0092 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State Director 1 Yes 2 No Examiner must be notified Preston Caroline Md. 10f. Zip Code 10g. Citizen of What Country? 23a or 2 10e. Street and Number USA Funeral 21655 62 P.O.Box 'natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: Black 3 🗌 Widowed 4 🔲 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within 72., h and Mental Hygiene.
7 is marked other than "r College (1-4 or 5+) Preston Trucking Elementary/Seconday (0-12) <u>Acct. Receivable Clerk</u> Willie, Maryland Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Carvilla permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke Johns injury or other traumatic Peter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rev. Joseph Williams, Old Orchard Rd., Baltimore, Md. 21229 lenora Itimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04-01-11 | Hurlock, Md. Washinton Cem A. Name and Address of Facility Bennie Smith funeral Home uneral Service Ling see any St., Hurlock, Md 21643 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 25a, Part 1, Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Onset and Death Immediate Cause (Final Pnysician/ STAGE disease or condition Medical resulting in death) Due to (or as a consequence of MONTALS **Examiner** FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant Month Day in the past 12 months?

1 Yes 2 No
9 Unknown Other (specify) Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural 5 Pending after death. Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide npleted filled in by 4 Homicide determined 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MARCH 24 2011 of person who completed cause of death (Item 23a) (Type, Print) DUTCHMANS LANE CRNP CIO State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 10:25 A M Jane Wojtkowski Medical Marc 27 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 6307 Foster Street Prince George's District Heights 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept 5, 1929 If Under 24 Hrs 9. Birthplace (State or Foreign Funeral Days 1 🗆 M 2 💢 F 81 Poland Director 181 26 3593 Usual Residence of Decedent 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🛣 No Maryland Prince George's District Heights 0 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 6307 Foster Street 20747 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 【 No If Yes, Give 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 5 þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: "natural", White Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cook Jiffy Shoppe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h ည Stanley Dym Mary Butkiewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Ed. S. Wojtkowski (Son) 4425 Bellwood Drive, Pomfret, MD 20675 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or of ☐ Burial 2 XXCremation 3 ☐ Removal from State 3/29/2011 4 ☐ Donation 5 ☐ Other (Specify) ee Crematory Clinton, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria MOISSS Ferry Road, Clinton, MD 20735 23a. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ 140 cardial Medical Examiner Saquentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a that the death certificate be executed and that initiated events resulting in death) Last attending physician Physician/Medical 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) use 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months? ō Month Day Yes 2 **N**0 the detached 9 Unknow P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? à 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Yes 2 N of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) iours after death.

neral Director: After the filled in by the funera 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending Division 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 24 hours Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 3-28-2011 pleted cause of death (Item 23a) (Type, Print) 6400 Menboro Pike, 103L 10 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 Physician/ Day Jesse Zimmerman Medical 8 2011 5:50a 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ManorCare Largo Prince Georges If Under 24 Hrs. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days Min. Hours Country) Director 435-12-4146 89 08 1921 Usual Residence of Decedent 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified ty∑ Yes 2 ☐ No Suitland MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5000 Lydianna Lane Apt. 430 20740 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1X Yes 2 ☐ No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 21 is marked other than "natural", traumatic event, the Medical Exai 3 Widowed 4 Divorced Specify: Completed 1945 Black Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Laboratory Technician Federal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Jice Zimmerman Mildred Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5000 Lydianna Lane Apt. 430 Suitland, MD 20740 Lillian E. Zimmerman/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 02/25/2011 Ft Brentwood, MD 21. Signatu Service Licens 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20744 23a. Part 1 Inter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Jo the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial Innerial record, page 2 should be detached for use as the burial-transit Anemia that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Generalised weakness Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy nis certificate ha I director, page 2 death?
1 Yes 2 No performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 💢 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina M 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oludara Olubayo 7245 Hanover Parkway Greenbelt, MD 20770 31. Date filed (Month, Day, Year)
FER 2 4 2011 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - 24 - 2011 Physician/ Month 03 Dawn Marie Zukas 5:05 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Wicomico Coastal Hospice at the Lake Salisbury 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F 8/2/196 43 Director 212-92-3100 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director 1 Yes 2X No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 115 Austin Circle 21811 USa 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, o. Black, White, etc. þ 1 Never Married 2X Married 1 ☐ Yes 2 No Specify. Specify: white "natural" 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Deane James Virginia Ruth Sexton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Zukas / husband 115 Austin Circle, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State First State Crem. 3/25/2011 5 Other (Specify) Millsboro, DE 22. Name and Address of Facility Burbage Funeral Home ice Licensee 108 William St., Berlin, MD 21811 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failu Immediate Cause (Final disease or condition resulting in death) art failure. List only one cause on each line Ph_sician/ ADRENAL Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of, attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Month Day Year Pregnant at time of death detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: The Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence Char (Specify) HOSP (CR မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated.

Representation of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

Within 2 To the

only one)

29b. Signature and title of certifier

atturny walke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

well

32. Redistrar's Signature

00058410

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 2011 Margaret E. Anderson 11:59A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c, County of Death Bright View Assisted Living Baltimore Catonsville Social Security Number If Under 1 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, June 28 Year If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign Hours Min Maryland 213-03-9464 Director 93 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---- any injury or other than "-----10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10g, Citizen of What Country? Funeral 21228 912 South Rolling Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Administrative Assistant Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Herbert L. Fleming Margaret Kealey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37188 Sugar Hill Way Selbyville, DE 19975 John F. Fleming, Jr., Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) orraine Park Cemetery 04/18/11 Woodlawn, Maryland 21. Signature of Funeral Service License Thomas Gregor 22. Name and Address of Facility
MacNabb Funeral Home, P.A.
301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death certificate has been signed by the irector, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 2 🗆 No 2 1 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: Assisted ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specific After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending ours after death.

neral Director: Aft
filled in by the fur 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a Certifier within 24 hor To the Fune completed fi Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items 28a-f per me g921 11-4-11 vt 23a
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PRIL 9:109 LUTHER RANDOLPH ALLEN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death timore 7. Age (In yrs. last birthday) Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Hours 02/05/1963 217-21-7387 Country) Director Yrs 48 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2XX No BALTIMORE CATONSVILLE 23a or 3 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 55 WADE AVE 21228 U.S.A. items within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 X Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Completed BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11th DISABLE permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt. once. N/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CHARLES EUGENE ALLEN JR. ALMA MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALMA MOORE/MOTHER 3815 N. ROGERS AVE. BALTIMORE, MD 21207 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 04-14-2011 BALTIMORE, MD 21. Signature Funaral Service Licensee william C. Brown Community Funeral Home P.A. 1206 W. NORTH AVE. BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval ween Onsel and D ath Immediate Cause (Final Physician/ (R) subclavian = x zuguination due disease or condition Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): signed by the attending physician and a betached for use as the burial-transit that the death certificate be executed CERTIFICATION APPROVED THEDICAL EXPLANATION Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 🗷 No 1 🔲 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28b. Time of inju**8: 30p** 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred **subject unclamped dialysis** 5 Pending Apr. 11, 2011 fd. 1 Yes 2 X No ☐ Accident ☑ Suicide Investigation catheter ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 55 Wade Ave Catonsville, Md. 4 Homicide state mental health hospital Catonsville, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0068107 April 11,2011 and address of person who completed cause of death (Item 23a) (Type, Print) 900 South Coton Avenue Ballimore lillarrea M.D 31. Date filed (Month, Day, Year) Registrar's Signat State APR 1 4 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Maryland Department of Health and Mental Hygiene State of Maryland Department of Health and Mental Hygiene 1952 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2011 Mary Jean Brown 4:05 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5169 Viaduct Avenue Halethorpe Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🕅 F Hours July 2. New York Director 122-09-6661 Ĩ922 88 Usual Residence of Decedent or 28a-f show be filed within 72 hours after death with the Maryland 10a State 10h County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Baltimore Halethorpe 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 5169 Viaduct Avenue 21227 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or other traumatic. Miller Bone Dorthea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Brown (son) 802 Hiddenbluff Cir. Catonsville, Maryland 21228 20a. Method of Disposition
1 □ Burial 2 🏅 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, Atlantic Crematory Apr. 5,2011 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ MMP, Inc.7250 Washington Blvd. Elkridge, MD. 21075 MEDSEL art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Cerebravasculis disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions Examiner Disk to for each epresquance of If any leading to in medicause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a ☐ Yes 2 L ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed empheril Unsular Difease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has blirector, page 2 s autopsy perform death? 2 🗆 No 1 🗌 Yes Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? 힏 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 K Residence 6 C Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral Manner of Death Certificate: 28h Time of 28c. Injury at work? 28d. Describe how injury occurred After Natural 5 Pending in 24 hours area he Funeral Director: Aft 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time. Sate and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Koud Cathoritle no 21228 1120 N. Rollan Bucaklu

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

4

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4 PRII Year 2:30 PM Genevieve C. Butera 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Future Care Chesapeake Arnold Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 1 M 2 F Months Days Min Hours 82 Vrs Director 216-28-9020 Maryland 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at **Funeral Director** 28a-f 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 23a 1329 Cape St. Claire Road 21409 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ö þ 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. 3 ₩ Widowed 4 Divorced "natural" Completed Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th grade Government Office Assistant other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o ၉ Joseph Cresta Antoinette Ursine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guy Butera -SON 1329 Cape St. Claire Road, Annapolis, MD 21409 Baltimore, 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department o Important: If any injury or ö 4 Donation 5 Other (Specify) Metro Crematory INC 04-14-2011 Baltimore, Maryland gnature of Funeral Service Licensee Patrik Fleming 22. Name and Address of Facility Cremation Society Of MarylandINC Road, Baltimore MD 21228 299 Frederick Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Phy i ian UROSEP disease or condition resulting in death) 51 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or ii that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? certificate 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certified completed filled in by the funeral director; I Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ✓ No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) APRIL 13 2011 D57531 MID 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (Month, Day, Year)

Veterans

sistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aphonth 11, D2011 5:15 A Sophia J. Bunting Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2091 Road St. James Howard Marriottsville If Under 1 Year If Under 24 Hrs. 6. Sex Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 87 Days 1 🗆 M 2 🕱 F Month Day.) /6/1924 217-14-1432 Director MaryTand Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Howard Marriottsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2091 St. James Road 21104 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Chemist Food Lab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Paul Klimczak Theresa Kapitan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21204 <u>Judith A. Emerson / Niece</u> 2091 St. James Road Marriottsville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date cemetery, crematory or other place)
Dulaney Valley Mem. 1 🗓 Burial 2 🗆 Cremation 3 🗔 Removal from State 4/14/2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RIMUN Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Day 1 Yes 2 No signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia MO -azn 31. Date filed (Mo State Registrar

amend item 19 and from 15 and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:15 A M Physician/ AMTI 1⁰ 201°± Ρ. Brundage Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Emeritus of Towson Towson Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days Selsenth, Bay, 19919 1 □ M 2**X** F Hours 91 New York Director 326-12-6431 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director : If item 27 is marked other than "natural", or items 23a or 28a-f s or other traumatic event, the Medical Examiner must be notified Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 N. Charles Street U.S.A. 6451 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2X No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Budget Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zachary Patsalos Constance Mingas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Karen W. McNaughton / Daughter 3414 Tree Farm Road Hillsborough, NC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 4/16/2011 New Windsor, New York 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ STroke month disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death Leat Physician/Medical Examiner Due to for as a consequence of: Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be to within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in by the funeral director, page 2 should be detached for use as the burn. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No Yes 2 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ Assisted Win 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier D0070635 38. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pute haves 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year 201 8:15 AM ingham Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regional Hospi Prince aurel aurel eorge Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 1 ☐ M 2 🕮 Months Hours Min May 22, T919 Director 212-30-6835 91 Marvland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10h County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2XXNo MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Leishear Road 8445 20723 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3**XX**Widowed 4 ☐ Divorced Specify: Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. the 8th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed.
Department of Health and Mental H
Important: If item 27 is marked ot
any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ည Clarence Edward Frazier May Evelyn Blakemore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan E. McKay/Daughter 8445 Leishear Road. Laurel. MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 4/13/2011 Savage Cemetery Savage, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or yeart failure. List only one dause on each line. Approximate Interval Between Onset and Death Physician Massive Side Cerebrovascular accident disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director; After filled in by the funer (Month, Day, Year) Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 7300 Van Dusen Rd. s of person who completed cause of death (Item 23a) (Type, Print) -aurel Regional Ho Laurel, MD 20707 uresh Malik,

State

Registrar

31. Date filed (Month, Day, Year)

4

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

AMEND ITEM#I/perfH, G918,8/19/2011,WS

State of Maryland / Department of Health and Mental Hygiene

1- State Amend Items 41,15,17,18,20b per fh/vr,g918,08/12/2011dhb

Reg. No. 2 | | | Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13^{ay} April 10:50 AM 2019 Herta E. Bregar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tate Chesapeake House Linthicum Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral . Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 😾 Days (Month, Day, Yea 5/9/1940 254-66-3890 **Director** 70 Yrs. Germany Usual Residence of Decedent 28a-f show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Lansdowne 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1st Avenue 121 21227 USA Germany 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hlspanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) rould be filed within 72 Ind Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Mfq. Be Anton Ewald Born Schiessinwald Anton Ewald Born Schiessinwald Anton Ewald Born Schiessinwald 18 Mother's Name (Eirst, Middle, Maiden Surname) Helene Pauline Hesselbach ည and 2 should the Health and Meter tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Ray Valett / Niece 4 Belleview Drive, Severna Park, Maryland 21146 permit. Page 1 and. Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, cremetery the there place 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) Paul Kutheran 4/18/2011 Violetville, Maryland Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. 22. Name and Address of Facility 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ nn Cancer MONTAS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Examin that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes No Year Day Pregnant at time of death signed by the a d be detached f g Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cirrhosis To the Hospital or Attending Physician: The law requires i within 24 hours after death.

To the Funeral Director: After this certificate has been sign Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page perform 2 No Yes 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No HUSPICE ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie aNB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Hanover St. Bultimore ECNO, MD 3001 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 Year April 11, 7:00 P M Sybil Dean Bostian Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4724 Boiling Brook Parkway Rockville Montgomery Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Months Days Hours October 1 450-70-3400 **Director** 68 Texas Usual Residence of Decedent or 28a-f show s notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Tes 2 X No Maryland| Montgomery Rockville 10e. Street and Number items 23a or ner must be r ö 10f. Zip Code 10g. Citizen of What Country? Funeral 4724 Boiling Brook Parkway 20852 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. ō by 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked or traumatic ever ၉ Eugene Mach permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. once. Amanda Roensch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robyn Leenaerts / Daughter 4724 Boiling Brook Parkway, Rockville, Maryland 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 15, Mt. Calvary Lutheran Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) La Grange, Texas 2011 21. Signature of Fun Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1/Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line nterval Between immediate Cause (Final Onset and Death Physician/ Acute Cardiorespiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Chronic Hypertensive Heart Disease Sequentially list conditions Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence oi). Hospital or Attending Physician: The law requires that the death certificate be executed and I-trans Congestive Heart Failure physician ar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending pd be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🗓 No Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an s certificate has the autopsy performed? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tyes 2 🔀 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) this 27, Manner of Death 28a. Date of injury (Month, Day, Year) s after death.

I Director: After the in by the funera Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 29b, Signature and title of certifier 29d. Datę signed (Month, Day, Year) 232

State Registrar DHMH 17 Rev 7/2009

nv

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Weihan Wang, M.D.

Day, Year)

31. Date filed (Month,

3

15245 Shady Grove Road, #130, Rockville, Maryland 20850

d ct

2/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 28d per me,g922,12/05/2011dhb trar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Req. No. For State A Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0 Physician/ VIRGINIA 2320 BARONE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CARROLL HOSPITAL CENTER Westminster Carroll . Social Security Number 6. Sex 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Dec. 31, **Funeral** 9. Birthplace (State or Foreign ^{Year)}1924 1 □ M 2 🛛 F Hours New York 86 Yrs. Director 090-18-7322 Dec. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10508 Willow Vista Way Cockeysville No within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Meury or other traumatic event, the Me College (1-4 or 5+) N/A Elementary/Seconday (0-12) 12 Supervisor Pharmaceutical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Grasso Rosario Cordona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Barone/Son 10508 Willow Vista Way Cockeysville, MD 21030 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 13, permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 2011 Glen Burnie, MD 21. Signature of Fu 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Road Timonium, MD 21093 Michael J. Flagle 23a. Part 1 Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death INTRACRANIAL BLEED Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to jor as a consequence of or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
g ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 4 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Within 24 hours after death.

To the Funeral Director: After this certificate has language and a filled in by the funeral director, page 2: autopsy perform 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Hospital: Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of .28d. Describe how injury occurred ${f Subject\ fell}$ 28c. Injury at injury 1 Natural 2 Accident 5 \square Pending 04/08/2011 1 Yes Investigation 1530 2 HNo 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined LIVING FACILITY ASSISTED 639 MAIN ST. REISTERSTOUN MODISO Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titl 29c. License number סטט 519 בון 29d. Date signed (Month, Day, Year) 062362 140 (14) MO Despara 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Herbert

31. Date filed (Month, Day, Year)

2973 MANCHESTER RD.

rack

Henderson MD

4

200 MEMORIAL AVET

DESHA KELLY, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 03:52AM Thomas Joseph Blair 04 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE MD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. | 24,1928 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months 214-24-9851 **Director** Sept. Maryland 82 Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1100 Mt. Carmel Road 21120 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 M Married þ $\mathcal{L}\mathcal{L}\mathcal{H}/\mathcal{K}$ $\mathcal{I}\mathcal{H}\mathcal{OM}\mathcal{H}$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 Divorced If Yes, Give Specify: Completed Year or Dates. 51'-57' permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) N/A Elementary/Seconday (0-12) Branch Manager Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Payne Blair Elizabeth Kahler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth C. Blair/Wife 1100 Mt. Carmel Road Parkton, MD 21120 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Garrison Forest Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State Owings Mills, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 tr Padonia Road Timonium, Maryland 21. Signature of Fu Flagle put 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ EEDING disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician and physician and the purial-t Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AFIBB. DYSLIPIDEMFA. AUTHERMERSDISENSE Division of Vital Records, or Attending Physician: The law requires 1 🗆 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an AVM, HTM, DUODENAL ULCER, HEPATITUSC page 2 s has autopsy perform 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ဂ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending n 24 hours after death.

e Funeral Director: At a leted filled in by the fu 1 Yes 2 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hour To the Fune completed file 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number soutist Kolbya RES 000 04/10/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENBLUD, BALTIMORE MD 21239 SATISH KABRA MD 5601, LOCH RAVE 31. Date filed (Month, Day, Year) Registrar's Signature State APR 1 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #80 Per DVR G914 4/14/2011 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 25, Day 2011 11:05 PM John M. Brode Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Devlin Manor Nursing Home If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 6. Sex 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 💢 M 2 🗆 F Months May 7, 1932 Days Hours Maryland 78 Director 217-28-0211 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene.
Important: If tiern 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location Director 1 Tes 2 X No Cumberland Allegany MD10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21502 USA 235 Paca Street #808 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14 Bace - American Indian Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced mk 16a. Decedent's Usual Occupation 15. Decedent's Education 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working College (1-4 or 5+) Elementary/Seconday (0-12) life. DO NOT use retired) laborer Be 17, Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ဂ Mary Mae Nelson Harry Edward Brode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10409 Christie Road NE Cumberland, MD 21502 Howard V. Brode/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature Funeral Servic Licens State and Address of Food of the Baltimore Street frector 21201 Baltimore, MD Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, at heart failure. List only one cause on each line. 23a Part Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ CONGESTIVE Medical Due to (or as a consequence of) **Examiner** Samentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No DISEASE 24a. Was an autopsy performed? After this certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending within 24 hours after death.

To the Funeral Director: After completed filled in by the full 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurses Practioner: To the best of his y in owledge, death occurred at the firm, data and place, and due to this dount(s) and more 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MARCH 31 2011 1) 26907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland ,MD 21502 Harjit S. Sidhu Devlin Manor Nursing Home 31. Date filed (Month, Day, Year) 32. Registrar's Signature State barks Registrar

11-02574 David Brock Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Jav	IG BIOCK		1- For State Registrar	e or iviaryland		icate of De			∠ U Reg. No.	11 11906	
Physician/ Medical Examiner			1. Decedent's Name (First, Middle,				•	2. Date of De Month	Day Year	3. Time of Death 0810 hrs	
Niedicai Examiner			David Lee E)	4b. C	ity, Town, or Location	April 4, 2	4c. County of		
			3111 East Preston Street				altimore		N/A	N/A	
	Funeral		5. Social Security Number 6	. Sex 7. Ag	ge (In yrs. last b					Birthplace (State or Foreign	
	Director		378-80-9330 1 xm 2 F 40 Yrs.				Months Days Hours Will.				
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Reath and Mental Hygiene. Important: If item 27 is marked other than "oatural", or items 23a or 28a-f show any injury or other traumatic eveot, the Medical Examiner must be notified at socce.	al Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. I							10d. Inside City Limits	
			MD N/A			Ва	ltimore		1 X Yes 2 No		
			10e. Street and Number		•		f. Zip Code		10g. Citizen of Wha	at Country?	
7			3111 E. Prest		Francis II C	T42 Was Da	21213	nin2 / Specify Vos or h	U.S.A.	American Indian, Black,	
7		Funeral	11. Marital Status 1 X Never Married 2 Marr	ied 12. Was Decedent			pecify Cuban, Mexicar	igin? (Specify Yes or N n, Puerto Rican, etc.)	White,		
6		eted by Fu	3 Widowed 4 Divor	1 Yes 2 ced If Yes, Give Year or Dates:	₩ <u></u> NO	1 Yes	2 No specify	:		Black	
			15. Decedent's Education (Specific Elementary/Secondary (0-12)	only highest grade cor College (1-4 or	' '		sual Occupation (Give f working life. DO NOT		16b. Kind of Bus	iness/Industry	
	136 hin 72 e. than	plet	12th Grade	College (1-4 or	5+)	Bus D	river		Greyho	ound Charter	
	5-00 ed wit fygien other	Comple	17. Father's Name (First, Middle, La	ast)				r's Name (First, Middle	, Maiden Surname)		
	Baltimore, MD 21215-0036 oemit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than njury or other traumatic erees, the Medical	To Be	John Brock	(T. D.)		40k 84-10 Ad		ry Carra		Olata Zia Cada\	
			19a. Informant's Name/Relationship Mildred Corni		11.5			mber or Rural Route Nu		, MD 21213	
	e, N l and 2 Health item 2		20a. Method of Disposition		20b. Plac		(Name of cemetery,	Date	20c. Location - 0	City or Town, State	
	Pages ent of unt: If		1 Burial 2 Cremation 4 Donation 5 Other Spec		ale		•	04/12/1	1 Baltim	more, MD	
	Baltin permit. P Departme Importar injury or		21. Signature of Funeral Service Li	censee	1 *	22 Name	and Address of Facility	own Jr.	Funeral	Home PA	
			21. Signature of Funeral Service Licensee 22. Name and Address of Facility JOSEPH H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD2121 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva								
	Physician Wedical Examiner		failure. List only one cause on each line.								
			Immediate Cause (Final disease a. Quetiapine Intoxication or condition resulting in death) Due to (or as a consequence of):								
		<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
		Examine	cause. Enter Underlying Cause								
	ansit	Exa	events resulting in death) Last Due to (or as a consequence of):								
	'60, ate be executed ohysician and ne burial - transit	dical	IF FEMALE: 23a, 27, 28a-f per me g915 5-4-11 vt 23d. Date of delivery								
	760, icate be physici the buri	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregnan	· —	2 Fato ni	in arrangement.	23d. Date of d		
	Box 6876 e death certificat the attending phy ed for use as the	ician	past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (Specify)						Day Year		
	BO) he death the att	Physician/N	1 Yes 2 No 9 Unkno	9 Uliknowii				Log- Did	4-1	oute to the cause of death?	
	P.O.	by P	Part II. Other significant condition	18 contributing to deat	h but not resul	ting in the under	lying cause given in P			Probably 4 V Unknown	
	ds, lequires	sted						24a. Wa		ere autopsy findings available	
	e law r e has b ge 2 sh	Completed				· · · · -		perl	formed? de	ior to completion of cause of eath? Yes 2 No	
	Division of Vital Records, P.O. Box 68760, To the Hospital or Atteodiog Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		25. Was case referred to medical			-		(Check only one)	2[_]10	V 100 2 110	
		To Be	1 Ves 2 No 1 inpatient 2 Erroutpatient 3 DOA 4 Nuising Notice 3 Residence 5 Vesidence 5 Ve								
		icati	Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rurs							r or Rural Route Number, City	
	Div bital or urs after ral Div	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3111 E. 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3111 E. 28f. Location (Street and Number or Ruin or Town, State) 3111 E. Baltimore, Md.							E. Preston St.	
	Divis To the Hospital or A within 24 hours after To the Fuoeral Direct completely filled in the	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
			one) 2 Medical Examl 29b. Signature and title of certifier	and manner stated.		or investigation,	29c. License number			d (Month, Day, Year)	
			In meal Add	and and			O.C.M.E.		April 5, 201		
			30. Name and address of person who completed cause of death (Item 23a)								
			Pamela E. Southall, MD				enn Street, Baltir	more, MD 21201			
	S	tate	31. Date filed (Month, Day, Year)	32. Redistra	r's Signature	bar	w				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Clark Robert 1:454 M 2011 APTI Medical 4a. Facility Name (if not institution, give street and number, 4b. City Town, or Location of Death **Examiner** 4c. County of Death andallstown tospice If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Director 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 0d. Inside City Limits Director 1 Yes 2 No time re 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 10 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced 3/ack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name ပ litarden permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic OBer ar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number, or Rural Route Number, City or 2 Baltimore, 20b. Place of Disposition (Name of Location - City or Town, State 20c cemetery, crematory or other place) 23a. Part 1. Enter the disease, or complications that codsed the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Liver cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the burla Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the P.O. signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? this certificate 2 No 1 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 5 \square Pending 1 Natural 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mskajapahren.D 0,0057465 4/13/1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Ryapakh. M.D. 7835 Smith AV Baltimore, MO-21209, 5-703 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ April 201^{Year} 12:35 A^M 11 Coffav Eileen Josephine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore The Maples of Towson Towson 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) U.S. 4, 1910 1 □ M 2X F Months Days Hours Min. Ire land 213-05-6493 **Director** 100 Aug. Usual Residence of Decedent or 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 🔽 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 Horncrest Road 21204 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 Yes 2X No Specify 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Executive Secretary Rubber Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Coffav Joseph O'Donnell Mary Kate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 Mary Haub 11732 Cherry Grove Drive, N. Potomac, Maryland 20a. Method of Disposition
1 🖸 Burial 2 🗆 Cremation 3 🗀 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of I Important: If ite 4 Donation 5 Other (Specify) New Cathedral Cem. 4-16-2011 Baltimore ner I Ser 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ dvan 0 resulting in death) Medical Due to (or as a consequence of): several years Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner cause, Enter Underlying Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes ∠ ₩ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 【 No 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury Matural Natural 5 Pending 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Kartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c, License number 85 29b. Signature and title of certifier - Azzewi, M), 9/03/rankhu 59. Dr. Sunte 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

M DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 1, 2011 Colantonio 8:40 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours July 29, 1928 1 🔀 M 2 🗆 F 374-24-1047 82 Ohio Director Usual Residence of Decedent per it. Page 1 and 2 should be filed within 72 hours after death with the Maryland Det artment of Health and Mental Hygiene. Important: If item 27 is marred other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Rockville 1 X Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 14431 Traville Gardens Circle USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Completed by 1 Never Married 2 3 Married Yes Specify: White 1 Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry Millwright 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Colantonio Genieve Gallupoll Schiappa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Triple Crown Ct North Potomac, MD Charles Yanjanin altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul Cemetery 4-4-11 Weirton, WV 22. Name and Address of Facility Greco-Hertnick Funeral Home 21. Signatury of Funeral Service Licensee 3219 Main Street Weirton, West Virginia . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Fart 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions if any leading to immediate Due to for as a consequence of cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year certificate has been signed by the irector, page 2 should be detached Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 4 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of performed' death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔲 Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 068890 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Dr. Rockville, Maryland Summit Gupta, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature **State** APR 1 4 2011 Registrar

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State of Maryland / Department of Health and Mental Hygiene U 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Cox A8711 10 2011 10:29 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brightview Assisted Living Baltimore County Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F 86 Hours 346 16 1377 A0111 2 1925 Illinois Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ems 23a or 28a-f sh r must be notified a Maryland Baltimore Baltimore County 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7903 Rolling View Avenue 21236 USA ural", or items? 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced W II "natural" Specify: White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Steel Worker Bethlehem Steel Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles B Cox Ruth McImturf 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2828 Munster Road Parkville, Md. 21234 Charles Cox (Son) Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dulaney Valley Mam. Gdns. April 12 2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service License ²⁴Lassann Aftineraichone Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, *** mplications that caused the deshock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Mospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical C Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 1 Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Natural Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 7 certifie 29d. Daje sig Month, Dav. Year) 0 31. Date filed (Month, Day, Year) State 4 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

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Physici	ian/	1. Decedent's Name (First, Middle,La	•					2. Date of Dea		3. Time of Death
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		4a. Facility Name (if not institution, g Baltimore Washington M	· · · · · · · · · · · · · · · · · · ·			r, Town, or Loca n Burnie	tion of Deatl	1	4c. County of De	
Funeral				n yrs. last bir			Under 24Hr	s. 8. Date of Bir	rth(MM/DD/YYYY) 9.	
Director		214-52-8729 1 M 2 F 61 Yrs. Months Days Hours Min. May 1, 1949 Foreign Country) Maryland								
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fter de I", or	y Fu	3 Widowed 4 Divorce	1 Yes 2 X ed If Yes, Give Yeer or Dates:	No	1 Yes	2 No spe	ecify:		Specify: Wh	ite
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215 be file ntal Hy rked o	Be (James Edward Ree	d			G	race	Leona Di	illinger	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment If item 77 is marked other than "natural", or items 23a or 28a-f ahe injury or other traumatic event, the Medical Examiner must be notified at once	70	19a. Informant's Name/Relationship		19	b. Mailing Addre	ss (Street and	Number or	Rural Route Nun	nber, City or Town, St	ate, Zip Code)
, MI and 2 s ealth a cm 27	nun	Mr. John B. Cund 20a. Method of Disposition	TII, JI./nus		of Disposition (N				20c. Location - City	
Baltimore, permit. Pages I an Department of Hea Important: If ite		1 X Burial 2 Cremation 3	Removal from State		tory or other plac		Apr	i1 ^{ale} 13		
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Balti permit. Departm Importa		23a. Part I, Enter the Isealar, or com	That Me	31.59				ngleton	Funeral &	Cremation
Physician		23a. Part I. Enter the seating or comfailure. List only one cause on e	plications that caused the each line.	death. Do n	ot enter the mode	of dying, such	as cardiac o	r respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
/Medical £xaminer		Immediate Cause (Final disease a. Pulmonary Thromboembolism								
		or condition resulting in death)	Due to (or as a conseque Bilateral Deep Ven	•	mboses					
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60, ate be executed hysician and te burial - transit	Medical	UNPENDED	AMENDED							
876(ifficate ng phy as the b		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome o		Fetal deat	h 3 TEC	topic pregna	incy	23d. Date of deliver Month	rery Day Year
Box 6876 ne death certificat the attending phened for use as the	Physiclan/	past 12 months? 1 Yes 2 No 9 V Unknow	Pregnant at time	of dooth	5 Other (Sp					
b. Be the de ched for	Phy	Part II. Other significant conditions	3 OTIKIOWII	t not resultin	a in the underlyir	o cause given i	in Part I	23e. Did to	bacco use contribute	to the cause of death?
Vital Records, P.O. hysician: The law requires that the this certificate has been signed by I director, page 2 should be detach.	ā	AL INCOME	•			•		1 Yes	2 No 3 P	robably 4 🗸 Unknown
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Atten rector by the	icati	2 Accident Investiga	28e Place of Injury	- At home, fa	arm, street, factor		_	28f. Location (S	Street and Number or	Rural Route Number, City
Div	Certification:	Suicide 6 Could not be determined (Specify) Suicide 6 Could not be determined (Specify)								
Division of Vital Records, P.O. Box 68760, To the Hospital or extrincing the Hospital or certificate be executed within 24 hours after details. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.		29a. Certifier (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
To t With To tl	Medical	29b. Signature and title of certifier	and manner stated.			9c. License num			29d. Date signed (
		Pot. O	- Pa00 e	_		O.C.M.E.			April 9, 2011	
.01	ŀ	30. Name and address of person who completed cause of death (Item 23a)								
101		Patricia Aronica-Pollak M			niner 111 F	Penn Street,	Baltimor	e, MD 2120	1	
St Regist		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature parks	1.					

DHMH 17 Rev 1/2001 OCME 2006

OCME

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 12^{ay} 2011^{ear} Linda Diane Carter 3:32P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 303 Sunshine Way Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Hours Min MD Country 218-58-3236 61 Director Usual Residence of Decedent shov 10a. State 10b. County with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 303 Sunshine Way 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black White etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: white Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Manager 12 traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gatewood Short Margaret Merson Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trau once. Brian Carter-son 516 Lexington Way, Littlestown,PA 17340 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) South Carroll Crem 4-13-11 Sykesville, MD 22. Name and Address of Facility Fletcher Funeral Home 1 Ε. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between COLUN Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or imjury that initiated events and Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 | Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown be detached for Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X N After this certificate 2 🗌 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No hours after death meral Director: A Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titl 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad EY RD TMONIUM, MD 21093 2300 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Scott P. Cheng a.k.a. Scott Cheng a.k.a. Scott P. H. Cheng a.k.a. Scott Pang Hua Cheng a.k.a. Scott Pang Hua Cheng a.k.a. Pang Hua Cheng 2. Date of Death Physician/ 12 Day Month Ам April 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care - Chevy Chase Chevy Chase Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **China Funeral** 7. Age (In vrs. last birthday) 1 👿 M 2 🗆 F Months Days (Month, Day, Ye January 6, Director 93 558-68-8129 Usual Residence of Decedent or 28a-f show 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2306 Peggy Lane 20910 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 4 Civilian Employee Department of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed h and Mental H 7 is marked ot ပ Unobtainable Unobtainable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Lillian Cheng/Wife 2306 Peggy Lane, Silver Spring, Maryland 20910 Date 1 14, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I-Important; If ite any injury or ot Montgomery Crematorium, Inc. 1 🗌 Burial 2 🛛 Cremation 3 🗌 Removal from State April 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda, Maryland 21. Signature of Funeral Service Licens Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. Haran M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death DEMENTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last and tran Due to (or as a consequence of): physician a Physician/Medical attending ph I for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 No page 2 certificate 2 KR0 1 Yes To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 PNo Hospital: Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \(\text{Yes} \quad 2 \(\text{No} \) 5 Pending injury Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainler as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Ero, MB 20057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V Truong Bao, M.D., 10110 Molecular Drive #206, Rockville, Maryland 20850

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month V 2 /Year Weldon Ira Crehan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Anne Arundel Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 Hours (Month, Day, Year) 27 83 Maryland Director 215 22 1899 Usual Residence of Decedent show 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st notified Anne Arundel Millersville Maryland 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 8049 Veterans Highway TR 62 21108 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 72 hours after 21215-0036 1 ☐ Yes 2 No Specify. White Completed 3 XWidowed 4 Divorced Year or Dates. WW II 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 3rd College (1-4 or 5+) and Mental Hygiene. is marked other tha Maintenance MD. State Police Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ew ပ Eugene Crehen Agnes Hittle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Parks / Niece 25596 Garev Road Denton, Maryland 21629 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 04/18/2011 Baltimore, Maryland 21. Signature of Funeral Service Licenses Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List Onset and Death Immediate Cause (Final nysician/ NGEST Medical resulting in death) 15e652 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury signed by the attending physician and d be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an prior to completic death? After this certificate has performed Yes 2 2 12 No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes/ 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work?
1 ☐ Yes 2 ☐ No after death Accident Investigation 3 Suicide 4 Homicide 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, 30. Name and address of person who completed cause of death (item 23a) (it.pe, Print) 21061 31. Date filed (Month, Day, Year) State

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Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 11, Day 2011 6:00P M Henry Thomas Curry Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium 5. Social Security Number 8. Date of Birth (Month, Day, Dec. I, If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Country Maryland 87 Yrs Director 217-14-0811 Usual Residence of Decedent 28a-f show 2 should be filed within 72 hours after death with the Maryland IIIh and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Baltimore Cockeysville 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10410 Greenside Dr. 21030 IISA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Maryland 21215-0036 þ 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify. Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William A. Curry Christine Kofron 19a. Informant's Name/Relationship (Type, Print) age 1 and 2 si cepartment of Health an Important: If item 27 is n any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Zugates/Niece Nottingham, MD 21236 4110 Slater Ave. 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Highview Cemetery $\bar{2}\bar{0}1\bar{1}$ Donation 5 Other (Specify) Fallston, MD Lemmon Funeral Home 10 W. Padonia Road 21. Signature of Fune Service Licenses of Dulaney Timonium, Michael Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of) disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to or as a consequence of Exami death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of): physician are the burial-t Physician/Medical Division of Vital Records, PO. Box 68760 attending ph I for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Dav Year signed by the a 9 Unknown Unknown law requires that the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 \square Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page, perforn this certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 🧳 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🛶 0 Hospital: Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending М 1 Tes 2 No within 24 hours after death

To the Funeral Director; /
completed filled in by the f Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and fir 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year John S.V. Cooper 700 M 01 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 667–18–7782 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 🕅 M 2 🗆 F Days Hours Min. **Director** <u>11-01-1935</u> iberia Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaitherburg 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 624 Lakeworth Dr. 20878 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify:Black Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Director of Procurement Government of Liberia 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Saye Cooper Sompu Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Cooper/ Wife 624 Lakeworth Dr. Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Paynesville Cemetery 5-14-2011 Paynesville, Liberia 22. Name and Address of Faciliti Ronald Taylor II FH 21 gnature Funeral Service Lice 10583 Middleport Ln. White Plains, MD 20695 DIVOLA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) hours after death.

neral Director; After the filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 63703 Orelle 11 7600 CARROLL AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARK, MD TAKONA SABYASACH UPR 31. Date filed (Month, Day, Year) 32. Registrar's S Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Maryland / De	partment of Health and Mertificate of Death	•	⁷ 9011 11973							
100	Physic /Medi		Decedent's Name (First, Middle, Last) FRANK A. CLARK SR.		2. Date of Death Month	Day Year 0 2011 4:03 a M							
1	Examir Funeral	er	4a. Facility Name (If not institution, give street and number) 250 OAK AVE. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death BALTIMORE (1) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death 9. Birthplace (State or Foreign							
	Director		249−36−9460 1X M 2 F 82 Yrs. Usual Residence of Decedent	ear) Country) S.C.									
	the Marylar 28a-f show	ector	10a. State 10b. County 10c. City, Town or MD BALTIMORE BA 10e. Street and Number	LTIMORE	100	10d. Inside City Limits 1 □ Yes ※□ No							
	with with Lee	Dir	250 OAK AVE.	10f. Zip Code 21219		Citizen of What Country?							
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiene. Important: If item 27 Ia markad other than "natural", or Itams 23a or 28a-f show any njury or other traumatic event, Ira Madical Examiner rougher and once.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 4 Divorced 1 Value 1 V	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:		U.S.A. 14. Race - American Indian, Black, White, etc. Specify: BLACK							
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Maryland	Mental Merkad o	To Be	ROBERT CLARK	INETHA		den Sumame)							
Mar	12 sho h and 7 la mu trauma			ling Address (Street and Number or Rura									
Baltimore, I	ages 1 and ant of Haalt t: If item 2 y or other		20a. Method of Disposition 1 Peurial 2 Cremation 3 Removal from State 20b. Place of Discemblery, ct		1219 20c. Location - City or Town, State								
Baltir	permit. P Depertme Impertan any njur.		21 Sometive of Funery Service License	LL MEM. GARD. 04-1 22. Name and Address of Facility ILLIAM C. BROWN CO 206 W. NORTH AVE.	MMUNITY F	ALTIMORE, MD UNERAL HOME P.A. MD 21217							
	Physician /Medical		294 Part 1. Enter the disease, or complications that ceused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac of SCULAY (4)	or respiratory arrest,	Approximate Interval Between Onset and Death							
1760,	eath certificate be executed attending physician and for use as the burial-transit	ai Examiner	sai Examiner	cai Examiner	icai Examiner	cai	cai	cai Examiner	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. ATHEROSCIE Due to (or as a consequence of):	rotic Cardio nsion pidemia	Vaseu	lar Dz 10 y . Ars
.O. Box 68	The law raquiras that the death certificate ba exacuted tie has been signed by the attending physician and bage 2 should ba detached for use as the burial-transit	Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year							
o, O	quiras that n signed by uld ba deta	þ	Part II. Other significant conditions contributing to death but not resulting in the Prostate Cancer	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?							
al Record		Completed			24a. Was an autopsy performed? 1 Yes 2 No 124b. Were autopsy findings a prior to completion of cardeath? 1 Yes 2 No 1 Yes 2 No								
Vital	nysician: Th sis certificate director, pag	o Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death									
Division of	ding Pt n. Aftar th funeral	\vdash	1 Yes 2 No 1 Noshitat. 1 Inpatient 2 ER/Outpatient 2. No 1 Noshitat. 1 Inpatient 2 ER/Outpatient 2. Noshitat. 1 Noshitat. 1 Inpatient 2 ER/Outpatient 2. Noshitat. 1 Inpatient 2 ER/Outpatient 2. Noshitat. 1 Inpatient 2 ER/Outpatient 2. Noshitat. 1 Inpatient 2 ER/Outpatient 2. Noshitat. 1 Inpatient 2 ER/Outpatient 2. Noshitat. 1 Inpatient 2 ER/Outpatient 2. Noshitat. 1 Inpatient 2 ER/Outpatient 2. Noshitat. 1 Inpatient 2 ER/Outpatient 2. Noshitat. 1 Inpatient 2 ER/Outpatient 2. Noshitat. 1 Inpatient 2	The same of the sa	me 5 Residence 28d. Describe how i								
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurr	ed at the time, date	and place, and due to the cause(s)							
	To To	W	29h. Signature and title of certifier	29c. License number D4298		P4 13 2-011							
			30. Name and Address of person who completed cause of death (non-22d) (Type J: KING, MD 9101 Fram	Klin Square De	#205 1	Balt MDZ1237							
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	D4298 klin Square Da									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 03:47 AM Medical 4b. City, Town, or Location of Death **Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death enesis Loch Raven Center 8720 Emge cial Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 D F Days Hours Min May 24 1926 216 20 1069 84 Director Baltimore Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Baltimore City Baltimore 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3209 Rosalie Avenue 21234 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Specify: Completed 3 Widowed 4 Divorced WW II Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If filed 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Letter Carrier US Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick DeBus B. Jeannette Watts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3209 Rosalie Avenue Baltimore, Maryland 21234 Norma B DeBus (Wife) Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place).
Parkwood Cemetery April 12 2011 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease complications that caused the deal Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Securations if any, leading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed Cause (Disease or iinjury the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospita 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town. State) To the Hospital o Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 A Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c, License number 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) ian 31. Date filed (Month, Day, 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4/12/2011 Harry Ronald Dove 6:00 P M Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 17345 Old Frederick Rd Airy Howard 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 1 □XM 2 □ F 773/1952 Director 217-48**-1**065 58 Usual Residence of Decedent 10b County 10c. City, Town or Location be notified at 10d. Inside City Limits Director 28a-f Marylhd Howard Mt. Airy 1 🗌 Yes 2 🙀 No 10e. Street and Number 0 10f. Zip Code 10g, Citizen of What Country? Funeral 17345 Old Frederick Road 21771 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married ☐ Yes 2 🗓 🗓 Yo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Service Tech. Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Wilber August Paul Dove Georgia E. Mullinix 19a. Informant's Name/Relationship (Type, Print) ... 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21771. Page 1 and 2 sh tment of Health a tant: If item 27 is Ina Dove 17345 Old Frederick Road Mt. Airy, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Place of Disposition (Name of cemetery, crematory or other place)
Resthaven Mem. Gardens 1 XXBurial 2 Cremation 3 Removal from State 16 Frederick, MD 4 Domation 5 Other (Specify) e o Funeral Service Licenses 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield, MD er the disease, or complications heart failure. List only one caus t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, neach line. Approximate Interval Retween Imm diate 0 use (Findisea e o ondition use (Final Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a con uence of) burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year ied by the a detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown a | Ilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page performed' 2 🔼 No Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tyes 2 🗹 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D69602 Amril 13 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANJ HAMMERS, 1650 Orlean, St. CRS1, Raltimore, MD 21231

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

Box 68760

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene Office 15 Per verb., g914,04/15/2011 hb 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Poris Dewey 3:15 A Medical 2011 April 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Earleville 4c. County of Death 235 Oriole Farm Lane Social Security Number 212-26-1015 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. (Month, Day, Year) 2/11/1929 Director Country) MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Nottingham 1 Yes 2 No 10f. Zip Code 21236 10g. Citizen of What Country? 10e. Street and Number 4614 Ridge Road Funeral 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 White If Yes, Give Year or Dates, 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) McCormik & Co. Food Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname)
Ethel Gorsuch ဂ္ Edward Kubin 19a. Informant's Name/Relationship (Type, Print)
Donna Knight / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 Oriole Farm Lane, Earleville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/12/2011 Final Journey Crem Woodbine, MD 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Eacility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Physician/ ESOPHA geal disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a done-guerre of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? ☐ Pregnant at time of death☐ Unknown Month Dav Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 24 hours after death.

Funeral Director; After this certificate I leted filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Daughter's

5 Daughter's

6 Dother (Specify) Residence Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MS Rajapahrel M.D 00057465 4/6/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21209 N. 5 Rayalpakse, M.D 9 2835 Smith AV - 203 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 4 2011 barke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10, 4:00 S. Day April Mary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Montgomery Carriage Hill | If Under 1 Year | If Under 24 Hrs. | Nonths | Days | Hours | Min. | Hours | Min. | Hours | February 8, 1913 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 🗓 F 183-12-9178 Canada 98 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or frame one of the market of the m 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Chevy Chase Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 3212 Woodhollow Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 2 3 Nidowed 4 Divorced Year or Dates: White Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner / Manager Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anastasia Kozar Andrew Sheptak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3212 Woodhollow Drive, Chevy Chase, Maryland 20815 Doris Day Welch / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 16, 20c. Location - City or Town, State 1 Bun'al 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 → M01596 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 pronths? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death funeral director, page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other:

Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30, ms 20057129 4112111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive, #206, Rockville, Maryland 20850 Troung Bao, M.D. 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar

DHMH 17 Rev 1/2001

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lames Evans	1- For State	tate of Maryla	-	artment of		d Mental		2 O eg. No.	978
Physician/	n/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day							ith	3. Time of Death
Medical Examine					b. City, Town, or		April 9, 20	011	0214 nrs
	4a. Facility Name (if not institution Johns Hopkins Bayvi	f Death N / A							
Europal	5. Social Security Number		7. Age (In yrs. I	ast birthday)	Baltimore If Under 1 Yea	r If Under 24	Hrs. 8. Date of Bi		9. Birthplace (State or
Funeral Director	o. obciai oscanty namboi	1XM 2F	31		Months Days		100	8/1979	Foreign
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5-0036 ed within 72 hour lygene. sher than "natu the Medical Exar Completed	10th		40(31)	Unemp	loyed			Unemp	loved
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b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygene. ten 27 is marked other than "natural", nr items 23a or 28a-f shur traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Sharon Lawso	n-Mother	Lagu	1110	Gorsuc	h Ave		nore, Mi	D 21218 City or Town, State
or Her	20a. Method of Disposition 1 X Burial 2 Crematio	n 3 Removal from		Place of Disposit crematory or oth		netery,	Date	20c. Location - 0	Jity or Town, State
Page ment trant:	4 Donation 5 Other S		We	stern (/16/201		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ur items 23a or 28a-1 shu injury ar other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Signature of leral Service	Livinsee			ame and Address	•			l E. North
Physician	23a. Part I. Enter the disease, o	r complications that cau	used the death.				MD 212		rt Approximate Interval
/Medical	failure. List only one cause	on each line.			, ,				Between Onset and Death
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Box 68760 e death certificate the attending physical for use as the bunder of versional mysical and Me	past 12 months?		nt at time of de		er (Specify)				
D. Box 68760 t the death certificate by by the attending physi ached for use as the bu	1 Yes 2 No 9 Un	9 ОПИЛОУ					oge Did t		oute to the cause of death?
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Page 15 Page 20 P							1 ✓ Yes		✓ Yes 2 No
Vital Records, vician: The law requirence, page 2 should director, page 2 should be Be Complete.	examiner?	11 11 11	nationt 2	ER/Outpatient		of Death (Che	rsing Home 5	Pesidence 6	Other
Division of Vital ral or Attending Physician rs after death. To Director: After this cert led in by the funeral director artification: To Be suffication: To Be suffication: To Be		28a. Date o	f Injury	28b. Time of In		y at Work?	28d. Describe	how injury occurre	
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Division o spital ar Attending hours after death. neral Director: After filled in by the func Certification:	4 V Homicide		Local Stree	et			or Town, S Bowley's Land	e @ Bowland Av	venue, Baltimore, MD
the Ho hin 24 I the Fu npletely		hysician: To the best aminer:On the basis of and manner sta	examination a						
Trans.	29b. Signature and title of certifi			_	29c, Licens	number		29d. Date signe	d (Month, Day, Year)
	Mlink	hamille	120		O.C.I	M.E.		April 10, 20	11
	30. Name end address of person Melissa Brassell, MD	-7.		_	enn Street, B	altimore M	1D 21201		
State	31. Date filed (Month, Day Year)	32 Reg	istrar's Signatu			Cimiloie, IV			
Registra		2011	me p	1. par					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AMonth GY a :53 AM 201 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Christ 51 05 Towsor Paltimore Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex . Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. 1 M 2 N 709 Country) Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No alt more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7619 errace LUSA 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. p 1 Never Married 2 Married Yes Yes, Give 2 10 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) vat omestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Ştate, Zip Code) 7619 erry Secution lerraco MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place, tark 16/2011 to Himore 4 Donation 5 Other (Specify) Mi 21. Signatu f Funeral Service 22. Name and Address of Facility altimore renn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 25 Matter! Medical Due to (or as a conseque e of): Examiner Morch 27,30 Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) transi Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): ending physician are as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ hed by the atter in the past 12 months?

1 Yes 2 No Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an \subset autops, performed's 2 No 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 X Na Hospital: 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral [Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29c. License number 30./Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Shelva Gean Engle 1:20P M Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) 1 □ M 2XXF Months Days Hours Min. 1072871943 Director 219-38-1587 67 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified Anne Arundel 1 Yes XX No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 133 N. Meadow Drive 21060 USA of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items
other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Completed by Black, White, etc. 1 Never Married 2 Married ☐ Yes XX No Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. If Yes, Give Year or Dates 3XXWidowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be John W. Crigger Georgia M. Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Susan Pearce / Daughter 19 Rector Court Apt. B Wilmington, DE 19810 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Glen Haven Mem. Park 4/15/2011 Glen Burnie, MD Funeral S 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 M01220 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exam Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown Day Year signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎘 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 🕱 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 LXNo 1 🗌 Yes Other: 욘 1 Minpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) funeral Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending injury work?
1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 17 Rev 7/2009

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AVIRIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-02782 State of Maryland / Department of Health and Mental Hygiene Russell Newton Esten 1- For State Certificate of Death Reg. No Registrar 2. Dete of Death Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2055 hrs April 11, 2011 **Medical Examiner** Russell Newton Estep c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Glen Wood 14540 Dorsey Mill Road If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplece (State or 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Days Hours Months Director Country) 230-92-8316 53 May 28,1957 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No s 23a nr 28a-f show e notified at nnce. Baltimore, MD 21215-0036

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 77 is marked other than "natural", or items 23a nr 28a-f sho
injury or inter traumatie event, the Medical Examiner must be notified at inne. MD Howard Laurel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20723 10340 Scaggsville Road 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funera White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X Married Armed Forces? 1 Never Married Yes Specify: White If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced ۾ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Communications Technician Audiovisual 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) June Newsome Be Herschel Estep 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Laurel, MD 20723 Elizabeth Humes Estep/ Wife 10340 Scaggsville Road. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) April 15, 1 Burial 2 X Cremation 3 Removal from State West Arundel Crematory 2011 Odenton, MD Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01053 313 Talbott Ave., Laurel, MD 20707 hou Jula Approximate Interval 26. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Retween Onset and failure. List only one cause on each line Death Marchical a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial 23d, Date of delivery Box 68760 23c. If ves. outcome of pregnancy IF FEMALE: Year Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. þ 1 Yes 2 No 3 Probably 4 Unknown signed l ð Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autonsy death? performed? 2 No Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Enspital or Attending Physician: 24 hours after death. Division of Vital Other: Nursing Home 5 Residence 6 Other: Scene examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Driver auto fixed object collision FOUND: 1 Yes 2 ✔ No Natural Pending Director: the Apr 11, 2011 2042 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 14540 Dorsey Mill Road, Glen Wood, MD Could not be Suicide determined (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) g Medi and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 12, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

APR 1 4 2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FRANK A. FORMICA 12 NOON M 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GENESIS ELDERCARE PERRING PKWY BALTIMORE N/A CITY Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs Funeral 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Hours 12-30-1925 219-10-9398 85 Yrs. Director MARYLAND Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits BALTIMORE ROSEDALE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8112 SAGRAMORE ROAD 21237 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 If Yes, Give 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed WHITE Year or Dates. 1944-46 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TECHNICIAN OFFICE EQUIPEMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **STEFANO** FORMICA **JEANNETTE** MOSAMIELO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $8\,1\,1\,2$ SAGRAMORE ROAD ROSEDALE, MD 21237 DOROTHY FORMICA/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State OAKLAWN CEMETERY 4-11-2011 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility CVACH ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee +211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ Due to ras a consiquence of): disease or condition resulting in death) Medical Examiner File Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Division of Vital Records, P.O. Box Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year ed by the a detached f 1 ☐ Yes 2 E 9 Unknown signed b d be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Onknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy after death.

Director: After this certificate! completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural work? 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 29a. Certifier Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, MD D31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. EUTAW ST Suite 308, BALTIMORE MD 21201 HASHMIMD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 per fh 915 5-26-11 yt State of Maryland 7 Department of Health and Mental Hygiene, 1 1 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 CHARLOTTE Physician/ FISH Μ. 4:30P M APRIL 8 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 9210 OSWALD WAY APT. ROSEDALE BALTIMORE Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🛛 F Months Days Min. (Month, Day, Year) 2-22-1932 216-28-79 Hours MARYLAND Director Usual Residence of Decedent f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE ROSEDALE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral APT. 9210 OSWALD WAY 21237 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates WHITE Completed 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th UNDERWRITER INSURANCE COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WALTER WYCZALEK **VERA** Κ. FERET 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. RICHARD P. FISH/SON 9210 OSWALD WAY APT 1A ROSEDALE, 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State OAKLAWN CEMETERY 4 Donation 5 Other (Specify) 4-13-2011 BALTIMORE, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME ROSEDALE, 1211 CHESACO AVE 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner horoscherolle Esquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam Hypertendon attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 1 Yes 2 Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe Yes 2 Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: No No 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pendina work? 1 ☐ Yes 2 ☐ No M after death

Director: A

in by the f Investigation 3 Suicide 4 Homicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) cal 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur 29d. Date signed (Month, Day, Year, of death (Item 23a) (Type, Print) ompleted 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ebruary Edward Thomas Folderauer 4:50 PM Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAL HOSPITAL OF BALTIMORE BALTIMORE ary Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 X M 2 - F Days Hours Min. Director 217-58-7530 56 10^M3'0'-1'9'54 Country) Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Harford Forest Hill 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 925 Delray Drive 21050 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunications Craftsman Verizon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ဂ Edward Folderauer Lula Belle Younger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth A. Folderauer (Wife) 925 Delray Drive Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 02-21-2011 Baltimore, MD 21. Signature of Funeral Service Lines 22. Name and Address of Facility Schimunek Funeral Home of BelAir any in once. Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death Aspiration Preumonitis disease or condition Medical resulting in death) Due to or as a consequence of) Examiner Cashcintestina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to (or as a consequence or) ON APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician CERTIFICATY use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year page 2 should be detached signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sub arachnoid hemorrhage Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? Brain Injur 24a. Was an Traumatic this certificate has autopsy performed 1 Yes 2 No Yes 2 N completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 24 hours after death.

Funeral Director: After Natural Accident 5 Pending work? 9-24-2010 8:13 AM M Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Roadway** 28f. Location (Street and Number or Rural Route Number, City or Town, State) **Level Road near** determined Canvasback Drive Havre de Grace
Maryland Medical Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Marylar

Marylar

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier 29c. License number 10ina Koppounesty RES -000 18 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROOPHARINESINGH MBBS SINA HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#25perME, G914,4/11 F2011, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Ethel Lorrene Phillips Fitchett 2011 Medical APR14 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL OF BALTIMORE BALTIMORE CITY 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 24 1932 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Min. 1 □ M 2 X F Davs 78 Country) Director 219-28-2110 MD Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f MD BALTIMORE 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 1190 W. 21210 Northern Pkwy Apt. 222 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. Baltimore, Maryland 21215-0036 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give 1 ☐ Yes 2 X No Specify: Black "natural" Completed 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important If Item 27 is marked other than "na any injury or other traumatic event". 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Fashion Boutique Assistant Boutique NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Sterling Phillips Helen Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1190 W. Northern Pkwy Apt. 222 Balto., MD 21210 Reba Fitchett Brothers-Dau. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. Donation 5 Other (Specify) 4/8/2011 rbutus Memorial Arbutus, March F/H West 4300 Wahash 21. Signatu of Funeral Service Licensed Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ASPIRATION disease or condition resulting in death) ~ 1/2 hour Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying CERTIFICATION APPRIONED BY MEDICAL EXAMINER Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 morths?
1 ☐ Yes 2 ☐ No Month Year Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown Completed FEMORAL ARTERY ANEURYSM 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 s r this certificate has autopsy performe death? Yes 2 No 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Yes Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 Tyes 2 🗌 No Director: A Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3. only one) 29c. License number 29d. Date signed (Month, Day, Year) David when TURKIMD DAVID RES-000 APRIL 2011 2 30. Name and address person who completed cause of death (Item 23a) (Type, Print) OF BALTIMORE State Registrar

PATIENT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month PRIL **Physician** LIZABETI+ 9.50 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4 theron House LUCHERN If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) curity Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Funeral Months 1 □ M 2 💢 F 212-18-3070 Director 2-23 MANY /AND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yd Director 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 16.5. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 XNo Specify. 2 Specify: Whit 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DWN HOME 12 to Memaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be heodore osches ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or 19a, Informant's Name/Relationship (Type. Print) Box New 4 P-0. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4-14-2011 Baltimere, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address Pacility Toseph N ZANNINO JR 21. Signature of Funeral Service Licensee Ku 5 23a. Part 1. Enter the decase or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart # ilure List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VASCULA RFBRO **Physician** THEKOSCLEROTIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Johnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 □ Yes 2 PNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred **♦** Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after deat To the Funeral Director: Medical

Maryland 21215-0036

Baltimore,

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

sucer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANI 32. Registrar's

DHMH 17 Rev 1/2001

265

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BRENDA MAE FLOYD-GREEN 2011 8:40p APRIL 11 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CENTER TOWSON BALTIMORE . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9–17–195] **Funeral** 9. Birthplace (State or Foreign 215-60-7024 59 MARYLAND Director Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A BALTIMORE XX Yes 2 No MD. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a oi Examiner must be Funeral 3208 BRIGHTWOOD AVE. 21207 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 X Married 🗌 Yes 2 🕱 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: BLACK 1 ☐ Yes 2 ☐XNo Specify. "natural", oe filed w_{nv.} Mental Hygiene. "•d other than "nats. •t, the Medical Ey Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HEALTHCARE NURSING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ္ other traumatic HERBERT BAILEY BESSIE JONES 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or any 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3208 BRIGHTWOOD AVE. BALTIMORE, MARYLAND 21207 ~GREEN(HUSBAND) 20a. Method of Dispos 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 A Buria 1 2 🗆 4 Donation Other (Specify) ARBUTUS MEMORIAL PARK 4-18-2011 BALTIMORE, MARYLAND 21. Signatur of Funeral Se HIBNER22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. Licenses MATHAN, D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1. Enter the dis shock, or heart failu Immediate Cause (Final Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line Onset and Death Physician/ disease or condition east Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Dav Year 9 Unknown Unknown ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given i*n* Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 🔼 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident
3 Suicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Cornell D Gray, J		State of Maryland / Department of 1- For State Certificate of			2011 1198
Physiciai Medical Examin	n/	1. Decedent's Name (First, Middle, Last) COTNELL Derrell Gray J	R.	2. Date of Dea Month April 8, 20	Day Year 1305 hrs
Ţ		4a. Facility Name (if not institution, give street and number) University Hospital	lb. City, Town, or Location of De Baltimore	eath	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 073-80-0033 1 M 2 F 19 Yrs.	If Under 1 Year If Under 24 Months Days Hours I	Hrs. 8. Date of Bir	th (MM/DD/YYYY) 9. 8 inthplace (State or Foreign Country) (SCHAN
er death with 1	by Funeral Director	1 Never Married 2 Married Armed Forces? If Ye 1 Yes 2 No 1 Yes 2 No 1 Obates:	10f. Zip Code 2/1/3 Decedent of Hispanic Origin? (ss, specify Cuban, Mexican, Pue) Yes 2 No specify:	Specify Yes or No rto Rican, etc.)	white, etc. specify: Black
5-0036 iled within 72 hours Hygiene. 1 other than "natus the Medical Exam	mpleted	Elementary/Secondary (0-12) College (1-4 or 5+) during mo	s Usual Occupation (Give kind st of working life, DO NOT use in 18.Mother's Na	of work done retired) me (First, Middle, N	Education Waiden Surname)
ore, MD 21215-003 s 1 and 2 should be filed within of Health and Mental Hygiene. If them 27 is marked other the for traumatic event, the Media	0 26	Cornell (Gray Sr (Father) 1836	Address (Street and Number of	or Rural Route Num	RandolpH nber, City or Town, State, Zip Code) OdenToN, MD 21113 120c. Location - City or Town, State
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traun		1 Donation 5 Other Specify:	er place)	-15-2011 Hawall	Laurel, MD Euneral Home
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	2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 7. Manner of Death 28a. Date of Injury 1 Natural 5 Pending Apr 6, 2011, 294, Year) 2302 hrs		28d. Describe h	Residence 6 Other: ow injury occurred icular collision
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To the Hospital within 24 hours To the Funeral completely filled	(9a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre theck only 2 Medical Examiner: On the basis of examination and/or investigation			
To with to con	2	9b. Stonature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) April 11, 2011
	3	O. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 21	1 201	
State Registra		1. Date filed (Month, Day, Year) 2. Registrar's Signature	,		
DHMH 17 Rev 1/2001		OCME ORIGINAL		······································	

DHMH 17 Rev 1/2001 OCME 2006

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1400	Examil	er	,		2 Hospital	Cente	r		edale	74.11	1	Baltin	
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	death r item iner m	F.	11. Marital Status		12. Was Decedent Armed Force 1 Yes 2	Ever in U.S.	. 13.	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.))-	14. Race - Amer Black, White	
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Giffings, To Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Nancy M.			ouse		ng Address <i>(Street</i>) Strawbr				r Town, State, Zip 11,Md.	
Gitting limore, Ma	1 and of Hea item		20a. Method of Disp	oosition		20b. Pla	ace of Dispo	osition (Name of matory or other pla		Date	20c. L	ocation - City or	Town, State
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Balt	permit Depart Impor any in		21. Signature of Fur	neral Service L	icensee		22	2. Name and Addre	-	Schimune oad ∥No			
			22a Dat Fatara	La dinasna av	complications that cause	ed the death.	. Do not ent					, , , , , , , , , , , , , , , , , , ,	Approximate
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Bo	e death the att hed for	Physician/Medical	1 Yes 2 5 9 Unknown	No	4 ☐ Pregnant 9 ☐ Unknown		eath 5	Other (specify)			_	Month	Day Year
$\mathcal{G}\mathcal{A} \not\vdash$ sion of Vital Records, P.O. Box 68760	the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physici mpleted filled in by the funeral director, page 2 should be detached for use as the bu	by Ph	Part II. Other signif	icant condition	ons contributing to death	but not resul	lting in the u	ınderlying cause gi	ven in Part I.	23e. Did	tobacco ı	use contribute to	the cause of death?
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cor	law rehas be	Completed								24a. Was	opsv	prior to c	opsy findings available completion of cause of
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∵ Vita	ysicia is certi directo	To Be	examiner?	□ No	Hospital: 1 ☐ Inpat	tient 2 🗆 E	R/Outpatier	nt 3 DOA Oth	or.	g Home 5 Res	sidence 6	6 ☐ Other (Speci	fy)
101	ing Ph	ate:	27. Manner of Death	5 Pendin	28a. Date of inj	urv 2	28b. Time of injury	28c. Injur		28d. Describe			~,
Sior	Attend death ctor: A y the f	Certificate:	2 Accident 3 Suicide	Investiç 6 🗆 Could i	not be April 6	, 201	Lunkno	eet, factory, office	Yes 2 No			nged sel	
DIVID	tal or /		4 🗌 Homicide	determ	building, et Home	tc. (Specify)				City or To	wn, State Pe	5109 Sti rry Hall	al Route Number, rawbridge , Maryland
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7	To the within 2 To the comple	Ž	only one) 3 29b. Signature and t	Cale of sections	Nurse Practioner: To the			00- 1:			00 I D		D. W. A
)	/				H6	286	2	Apr	11,06,	2011
	(3)		30. Name and addre	ess of person v	who completed cause of cranklin S	death (Item 2	23a) (Type, F	Print)	9000	renklin	Sal	yare pni	237
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	Registra	ar oc	APR 112	2011	Zenera J.	frank	1						.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #19ahb 20a Charles FH G914 4/20/2011 JH JH General #19ahb 20a Charles FH G914 House All Copies Are Legible. State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Gary Gnagey 3:16 PM APRIL 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number UNK | 6 Sav BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 unk **Funeral** 1 😾 M 2 🗆 F Nov 12, 1949 **Director** 61 Usual Residence of Decedent f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director MD 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 22 S. Athol Avenue USA unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu may injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk unk Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Adulto Protective Services 300 Mt. Boyal AVE. Balto. 19a. Mr. Ayo St. Agnes Hospital <u>21229</u> Md 21215 900 S. Caton Avenue Baltimore, MD 4/22/2011 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MT. Carmel Cem Balto.MD 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Skarda Funeral Home Signature of Funeral Service Licensee 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as carriac of respiratory arrest, shock, or in trifailure. List only one cause on each line. 5 W. Baltimore 2829 Hudson St Etreet Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ ARREST CARDIAC Medical Due to (or as a consequence of): **Examiner** UNKNOWN SPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a consuluence of attending physician and for use as the burial-transit death certificate be executed ころスそりらて MONIA that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical housen of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a 9 ☐ Unknown been signed by the should be detached g Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? e Hospital or Attending Physician: The law 124 hours after death.
9 Funeral Director: After this certificate has k leted filled in by the funeral director, page 2 s autopsy performe 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Yes ER/Outpatient 3 DOA 2 1 Inpatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🔑 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

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completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 [29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ARRIL 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 21229 AVENUE CEDRIC DARK SOUTH MD 31. Date filed (Month, Day, Year) APR 1 4 2011 32. Registrar Signat State

DHMH 17 Rev 7/2009

Registrar

		-	Please amend #8 - State Amend Item 25 Registrar	Type or Print in E Per FH G916 6 State of Marylan per me,g914,	Black In /16/20 1/16/20 1/05/ Cert	delible 11 JH 12011d	e Ink. Ensure t of Health and hb of Death	All Copies Mental Hyg	s Are Leggiene	gible.	11991
	Physicia	n/	Decedent's Name (First, Middle, Last					2. Date of Dea Month		Year 201	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give s	street and number)	al Car	4b. City, 7	Town, or Location of Dea	th	4c. Count		A
	Funeral Director		5. Social Security Number 6. Se		st birthday) Yrs.	If Under Months		s. 8. Date of Birt			hplace (State or Foreign Intry)
	yland •f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc		3.0				10d. Inside City Limits
	th the Mar 3a or 28a t be notifi	Funeral Director	10e. Street and Number	-1 040	Jalt	1 MC			10g. Citizen of	What Co	
39	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	lf.	Yes, speci	ent of Hispanic Origin? (if y Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ack, White	rican Indian, o, etc.
Maryland 21215-0036	ed within 72 hours Hygiene. other than "natur: ent, the Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Seconday (0-12)	lucation	(Give k life. DC		1 / '	orking	16b. Kind of Self	Business I	nployed
land ?	ild be filed v Mental Hyg larked othe atic event,	To Be	17. Father's Name (First, Middle, Last) Thomas	Hall			18. Mother's N	ame (First, Middle,	Maiden Surnar	/	nan
	and 2 should Health and M Iem 27 is mar Ither traumat		19a. Informant's Name/Relationship (Ty		19b. Mailin 4011	g Address	(Street and Number or F	Rural Route Number	3alto	. M	D 21215
Baltimore,	nit. Page 1 and artment of Heal ortant: If item: Injury or other		20a. Method of Disposition 1 Suburial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature Funeral Service Center (Specify)	Removal from State	lace of Disposemetery, crem	atory or of	ther place)	28/2011	Bal-	1 ,	Town, State
Ba	permit. Departr Importa any Inji		23a. Part 1, Enter the disease, or comp	Injuly In	. 4	600	Liberty	Height, ac or respiratory ar	S Ave	Ba	Approximate
1	nysician/ Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequ	Linoi	4	remorrha	ge	1		Interval Between Onset and Death
	ped isit	Examiner	Sequentially list conditions, fram leading to innuciate cause. Enter Underlying Cause (Disease or iinjury	b. Due to or as a consecu	ence of		7	ROVED BY MEDICAL	EXAMINER		
00	ath certificate be executed attending physician and for use as the bunal-transit		that initiated events resulting in death) Last	Due to (or as a consequence of): dCERTIFICATION APPROV							
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death. Within E2 hours after death. To the Tathorial pirector. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the buse to provide the provided for use as the buse to be a signed to the provided for use as the buse to be a signed to the provided for use as the buse to be a signed to the provided for use as the buse to be a signed to be a signed for the provided for the prov	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 Yes 2 ANo 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	ıldıeath 3 <u>L</u>] Ectopic p] Other (sp				Date of de Month	livery Day Year
ls, P.O.	uires that the n signed by uld be detac	2	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying (cause given in Part I.	23e. Did 1	\sim		the cause of death?
Division of Vital Records, P.O.	: The law req cate has bee , page 2 shoi	Completed						1 🗆 Yes	opsy ormed?	prior to death?	topsy findings available completion of cause of
/ital	s certifi	To Be	25. Was case referred to medical examiner? 1 4 Yes 2 No	Hospital:	ER/Outpatier	nt 3 🗆 D0	26. Place of Death (Co	neck only one) Home 5 Res	idence 6 🗆 0	ther (Spec	cify)
of	ing Phy vfter this uneral o		27. Manner of Death Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	2	8c. Injury at work?		how injury occi		
Jivision	al or Attendi s after death I Director: A d in by the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined		ome, farm, stre	M eet, factory	1 Yes 2 No	28f. Location (City or To		nber or Ru	ıral Route Number,
_	n 24 hours n 24 hours e Funera pleted fille	Medical	(Chook 2 Medical Evami	sician: To the best of my know ner: On the basis of examination se Practioner: To the best of my	n and/or invest	tigation, in	my opinion, death occurre	ed at the time, date	and place, and	due to the	cause(s) and manner stated.
	Vithin Congression		29b. Signature and title of certifier	2 41 7		29c	License number	2100 00 3	29d. Date sig	ned (Mont	h, Day, Year)
7	•		30. Name and address of person who c	completed cause of death (Item			C 4 C	10055C	210	1	MD 212-1
1	Sta		31. Date filed (Month, Day, Year) APR 0 5 20	32 Registrar's Signa	See ba	ne J	Juites	121) (altim	8101	NIE XIDOI
	Registr	ar	AFK U J ZU	11 Carried	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hoffmeister Rita P^{M} Medical 50 March 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🏝 F ADMIT 124 1933 328-28-5342 Illinois Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland Examiner must be notified at 10d. Inside City Limits **Funeral Director** Baltimore 1 ☐ Yes 2 🛣 No Maryland Lutherville 10e. Street and Numbe 10f. Zip Code 10q. Citizen of What Country? "natural", or items 23a 112 E. Aylesbury Road 21093 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Floyd Getzelman Holton May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Hoffmeister / Husband 112 E. Aylesbury Road Lutherville, Maryland 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp. 3/29/2011 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Li 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFICATION Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed HYPERCALCEMIA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 🗌 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide determined within 24 hours a To the Hospital Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier STESSO TOWSON, MD 21204 31. Date filed (Month State 08 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 01iver April 12^{Day} 2011^{Year} F. Heiser 5:20P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 105 Caswell Avenue Glen Burnie Anne Arundel Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F Year 1931 Days July 24, 79 Months Hours Min. **Director** 180-22-1061 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland must be notified at 10c. City. Town or Location Director 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 Yes XX No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 105 Caswell Ave 21061 USA filed within 72 hours after death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No o Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 🔀 No Specify: "natural" Completed 3 Widowed 4 Divorced Specify White Year or Dates or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Supervisor Domino Sugars Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ John W. Heiser Bessie Mae Becker permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Florence Heiser / Wife 105 Caswell Ave Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park 4/16/2011 Glen Burnie, MD uneral Se 22. Name and Address of Facility Singleton Funeral & Cremation M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 Part 1. Eater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part Approximate Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition Medical resulting in death) Due to (or a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events tran and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Year Day g Unknown g Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🏲 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy performed? Yes 2 No certificate ! 1 Yes Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Director: Af Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature a 3 2011

State Registrar

DHMH 17 Rev 7/2009

Glen Burnie, MD 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gurmeet Sawhney

31. Date filed (Month, Day, Year)

APR 1 4 2011

325 Hospital Drive

32. Registrar's Şignature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ALLEN 00 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Months Days 1 X M 2 □ F Hours Min Director 217-36-3991 07/17/1941 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f s notified 1 Yes 2X No Director MD Harford Abingdon 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō and 2 should be filed within 72 hours after death with ral", or items 23a or Examiner must be Funeral 2059 Knotty Pine Drive 21009 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 D No If Yes, Give Vietnam Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ş Specify. Specify: White 3 Widowed 4 Divorced "natural", Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Police Officer Baltimore County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental is marked 2 Woodrow Wilson Hicks Sarah Elizabeth Vincent 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Joyce M. Hicks 2059 Knotty Pine Drive - Abingdon, Maryland 21009 Department of Healt Important: If item 2 any injury or other once. injury or other Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/14/2011 | Baltimore, Maryland Parkwood Cemetery permit. ature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of) disease or condition resulting in death) /Medical Examiner Caricer static Sequentially list conditions, if any, leading to lumine list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 0 Due to for as a consequence of requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? be detached for Month Day Year Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 X No 1 X Inpatient $2 \square$ ER/Outpatient 3 🗌 DOA 5 Residence 2 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Yes 2 No 2 Accident by the f Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) RES-000 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hinson 600 North Wolfe St, Baltimore, MD, 21287 Holli . Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 4 2011

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland 4 Dog Ton Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 20°1 1 11:25aM Medical Marita Loretta Harvey 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Summit Park Rehab. Center Catonsville If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 9 12 34 1 □ M 2 🔽 F Months Hours Country) Director 213-30-2917 76 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If firem 27 is marked other than "natural" or item———
any injury or other trainment. 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No MID Baltimore NΑ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4103 Fairfax Road 21216 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Johns Hopkins Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade CNA Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Harrison Harvey Elizabeth Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leon Harvey-Son 4103 Fairfax Road, Baltimore, Md 21216 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Memorial Park 3/19/2011 4 Donation 5 Other (Specify) Woodlawn, Md 21. Signature of Funeral Service Libe 22. Name and Address of Facility
March F/H West 4300 Wabash Ave. Baltimore, 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician, PNEUMONI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner MEDICAL EXAMINER Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innertal Innertal nector, page 2 should be deteched for use as the burial-transit attending physician and for use as the burial-tran CERTIFICATION APPRO Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the s should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b ACRANIAL HEMORRHAGE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s autopsy performed Yes 2 K 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 X Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tyes 2 🗌 No Accident Investigation 2 ☐ Accider3 ☐ Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 586 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

HAMMONDS

Registrar's Signature

BALTI MORE,

11-02806 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Magealen Hair 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day April 12, 2011 1839 hrs Mediçal Examiner Magdalen Hair c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Baltimore 23 S. Curley Street If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State of 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours 69 Director 219-40-3740 March 30, 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 No or 28a-f show MARYIMD Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country 10e. Street end Number 5. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married Yes 1 Yes 2 No specify Specify: Divorced If Yes, Give Year 2 6b. Kind of Business/Industr 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) ment of Health and Mental Hygiene.
rtant: If item 27 is marked nther than 'n n nther traumatic event, the Medical Baltimore, MD 21215-0036 17. Father's Nariie (First, Middle, Last) (Street and Number or Rural Route Number, City or Town, ABIRD 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition crematory or other place) Burial -18-2011 Donation 5 Other Specify: 263 Kling 23a. Part I. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and one cause on each line Medical a Multiple Blunt Force Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated and - transit

Physician/Medical e attending physician for use as the burial certificate has been signed by the ector, page 2 should be detached Certification: To Be Completed by within 24 hours after death.

To the Funeral Director:
completely filled in by the f 3 Suicide

4 Homicide 29a. Certifier 1

29b. Signature and title of certifie

Russell Alexander MD. 31. Date filed (Month, Day, Year)

determined

30. Name and address of person who completed coase of death (Item 23a)

(Specify)

Rowhouse

Assistant Medical Examiner

events resulting in death) Last	Due to (or as a consequence or)	,				
d. UNPENDED	1	ted per me	e g914 4-14-1			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 Live birth 4 Pregnant at time of dea	2 Fetal death			23d. Date of delivery Month Day	Year
Part II. Other si inificant conditions	contributing to death but not re	sulting in the underly n	g cause given in Part I.			4 Unknown
25. Was case referred to medical			26.Place of Death (Check	only one)		
	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other Nursin		sidence 6 🗹 Other: Scen	10
27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigar	28a. Date of Injury FOUND: FOUND: Apr 12, 2011	28b Time of Injury FOUND: 1815 hrs	28c Injury at Work? 1 Yes 2 ✓ No	28d. Describe how Subject fell dov	wn stairs	
2 Accident investiga	28e Place of Injury - At ho	ome, farm, street, factor	y, office building, etc.	28f. Location (Street	et and Number or Rural Ro	ute Number, Ci

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

After this

Medical

State Registra

ORIGINAL

OCME

23 S. Curley Street, Baltimore, MD

29d. Date signed (Month, Day, Year)

April 13, 2011

21274

Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ April Knott 11 9:15 A^{M} Pauline Hammond Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 3210 N. Leisure World Blvd. #306 Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye May 21, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Hours Min New Jersey 147-03-0296 Director 92 Usual Residence of Decedent 28a-f shov 10b. County 10a, State death with the Maryland event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Montgomery 1 Yes 2 X No Silver Spring 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3210 N. Leisure World Blvd. #306 20906 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 5 ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3
Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o bermit. Page 1 and 2 should be 1.
Department of Health and Mental important; if item 27 is many injury or other ပ Paul Knott Mae Slocum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17213 Larosa Drive, Rockville, Maryland 20855 Harry Krewson Hammond, IV/Son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Parklawn Memorial Park 2011 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland ette Carris M01305 Part T. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
10 Years Immediate Cause (Final Physician/ disease or condition Osteoporosis Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): il any, leading to inmediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FÉMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Pregnant at time of death Day Year 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificate has been signe funeral director, page 2 should be Dementia, Hypertension 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 💢 No B B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other 2 🛛 No 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? X Natural injury 5 Pending | Director: Ad in by the f Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) R086637 April 12, 2011

Registrar DHMH 17 Rev 7/2009

State

CRNP 3250 Starting Gate Court, Woodbine, Maryland 21797

CRN

Nelle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ellen Reilley Farrell,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Henry Hart Jr. April Physician/ 1^{Day}, 10:45 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 337 Herring Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. **71 Funeral** Days Months 216-36-3206 1 🔀 M 2 🗆 F Hours 08/15/1939 MD Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b County 10d. Inside City Limits 10c. City. Town or Location Director Baltimore MD 1 XYes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code Funeral 21231 337 herring Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Black 1 Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Janitor Janitorial 12 Be 17. Father's Name (First, Middle, Last)
Henry Hart Sr. 18. Mother's Name (First, Middle, Maiden Surname)
Alia Hamilton 19a. Informant's Name/Relationship (Type, Print)
Henry Hart III / Son 19b. Mailing Address (Street and Number or Rural Route Number City of Town, State, Zip Code) 5245 Saybrook Road, Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XX remation 3 Removal from State 4/15/2011 Woodbine, MD 4 Donation 5 Other (Specify) Maryland Address of Growth Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Dorrota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **₽**nysician/ disease or condition OVONKN Medical resulting in death) Due to (or as a consequente of) Examiner Sequentially list conditions Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events -transit or Attending Physician: The law requires that the death certificate be executed 11 GOL ((M) and Due to (or as consequenc resulting in death) Last the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 ast IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 2 No the should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by VONTINE CARRENOVASC 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv certificate has page 2 performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 2 🗀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ♣ Residence 6 ☐ Other (Specify) this Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. Natural (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number use of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

1 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Bernadette Janet Hein $2\overset{\scriptscriptstyle{\mathrm{Year}}}{0}\overset{\scriptscriptstyle{\mathrm{I}}}{1}$ 2:15 P. April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6009 Ritchie Highway Baltimore Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last hirthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min 198 38 1772 **Director** 63 09/04/1947 <u>Pennsylvania</u> Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Anne Arundel Baltimore 1 Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 6009 Ritchie Highway U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Drumm Lillian Love 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6009 Ritchie Highway Baltimore, Maryland 21225 Barbara Stein / Daughter other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it cemetery, crematory or other place 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 injury c 04/14/2011 Baltimore, Maryland Bavview Crematory any in once. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or cor shock, or heart failure, list only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nterval Between Immediate Cause (Final 1 Pathy Physician/ disease or condition resulting in death) Medical Due to (or as a Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician and for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month Day Year Pregnant at time of death 5 Other (specify) Yes signed by the Unknown Unkno Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe After this certificate 1 Yes 25. Was case referred to medica B 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 6 Other (Specify funeral 28a. Date of injury (Month, Day, Year) 27. Manner of eath Certificate: 28b. Time of 28c. Injury at work?
1
Yes 28d. Describe how injury occurred tural 5 Pending 2 🗌 No Accident Investigation 24 hours after death Funeral Director: 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: 75 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 🗆 only one 29b. Signature and title son who completed cause of death (Item 23a) (Type, Print) and address of pe 210

DHMH 17 Rev 7/2009

State Registrar Year)

Physic Med Exam Funera Directo permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once. Baltimore, Maryland 21215-0036 Physician. Medica Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

		Pleas	e Type or Pri						-		_	ble.		
	for State		State of M	aryland /		artment of h			ental Hy	gien	e 201	1	12000	
	Registrar 1. Decedent's Name	o /First Middle	ant		Cei	rtificate of L	Jeath		2. Date of Dea	Reg. N	16 0	100		
an/ ical	George		.ası)						Month 04-10-	Г	oay L 1	Year	3. Time of Death 9:20 PM	
ner		· · · · · · · · · · · · · · · · · · ·	ive street and number)			4b. City, Town, o	r Locatio	n of Death			c. County o	f Death		
	Rockspri					For		Hill				arfo		
	5. Social Security No. 215–12–54		Sex 1 X M 2 □ F 7. Ag	e (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	Hours	Min	B. Date of Birt (Month, Date ept. I	th y, Year)	1920	9. Birthp Coun Ball	place (State or Foreign try) timore	
١.	Usual Residence of						-							
Funeral Director	10a. State	10b. County	.	10c. City, Tov								1	0d. Inside City Limits 1 ☐ Yes 2 🌠 No	
Dire	MD 10e. Street and Nun		timore	Lu	Luer	ville 10f. Zip Code				10a. C	Citizen of Wh	at Cour		
eral	8417 Th	orton R	oad			2	1093					SA		
	11. Marital Status		12. Was Decedent	Ever in U.S.	13.	Was Decedent of H	lispanic C	origin? (Specif	fy Yes or No-		14. Race			
qp	1 Never Marri		If Van Chia			1 ☐ Yes 2 X No			,,		Specify:	White, o	ite	
Completed		15. Decedent's			a. Dece	dent's Usual Occup				16b.	Kind of Bus			
	Elementary/Seco		grade completed) College (1-4 or :	5+)	Ìife. D	kind of work done on NOT use retired)	J	Ū	'		_		,	
Be C	17. Father's Name (First Middle L.	2		В	ank Exec						anki	ng	
일	Henry	,	i)				18. Mo	mers Name (i Meta	First, Middle, Schmi					
	19a. Informant's Na		(Type, Print)	19	b. Mailir	ng Address (Street	and Num					te, Zip C	Dode)	
	Debra	G. Schu	bert/Attorn	ney .	502	Baltimor	e Ave	e. 1st	. F100	r,	Towson	n, M	D 21204	
	20a. Method of Disp 1 Burial 2		☐ Removal from State	cemet	ery, crer	osition (Name of matory or other plac		April	^{te} 14,	20c.	Location - C	ocation - City or Town, State		
	4 Donation	5 Other (Spe	ecify)	Atlar	ntic Crematory 201 22. Name and Address of Facility						G1e1	n Bu	rnie, MD	
	21. Signature of Fur	neral service L	Michael J.	Flagle	L	emmon Fu	nera.	Home	of Du	lan	ey Va	lley	, Inc.	
	Lemmon Funeral Home of Dulaney Val. 10 W. Padonia Road Timonium. MD 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between		
	Immediate Cause (Final disease or condition Approximation Programme)											Onset and Death		
	resulting in death)		Due to (or as	a consequence	of):	1000		. h.						
je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):										+	ylars		
amil	cause. Enter Underlying Cause (Disease or linjury) that initiated events c.												<u> </u>	
	resulting in death) L													
edic			d									 _		
N N	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome			1					23d. Date	of delive	ery	
Completed by Physician/Medical	in the past 12 r		1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnand Other (specify)	су				Mont	h	Day Year	
Phy	9 Unknown Part II. Other signifi	icant conditions	contributing to death b	out not resulting	in the u	inderlying cause gi	ven in Pa	rt I.	23e. Did to	bacco	use contrib	ute to th	ne cause of death?	
d by	Chroi	ric =	Kidney	Dis	ec	rse	-		1 🗆				oabiy 4 🗆 Unknown	
plete			J						24a. Was		24b. We	ere autor	osy findings available	
E O									autop perfo 1 \(\sum \) Yes	rmed?	de	ath?	mpletion of cause of	
Be	25. Was case referre examiner?		Hospital:					eath (Check o						
2	1 Yes 2 2 27. Manner of Death		1 Inpati	ent 2 ER/C	outpatier Time of		4 💆		e 5 Resid)	
cate	1 ☑ Natural 2 ☐ Accident	5 Pending	(Month, Da	y, Year)	injury	work		- 1	G. Describe fi	ow inju	ary occurred			
ertif	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine		ry - At home, farm, street, factory, office 28f. Location					f. Location (S	ation (Street and Number or Rural Route Number,			Route Number,	
Sal	00 0 15 1										<u> </u>			
Medical Certificate:	(Check 2		nysician: To the best of miner: On the basis of e urse Practioner: To the	xamination and	or invest	tigation, in my opinio	on, death	occurred at th	e time, date a	nd plac	ce, and due t	o the cau	use(s) and manner stated	
2	29b. Signature and t		~ 1	00	7	29c. License	e number				ate signed (
	10			11		Do	260	280	T	(74/1	1/5	2011	
	A for	epe Ris	o completed cause of d	leath (Item 23a)	(Type, F	hisani	ake	582 Dr	Bel	26	ir 1	ND	21014	
ate	31. Date filed (Mon)	PR 1 4 2	011 32 légiste	ar's Signature_	-,									
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